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PRESIDENT BACON REVIEWS TWENTY-FIVE YEARS OF ACHIEVEMENT*

TODAY marks the twenty-fifth anniversary of the American Hospital Association. As we look back over this stretch of a quarter of a century, it seems a long time—a long time since the first meeting in 1899. Our association has grown from an organization of a few hospital superintendents to a powerful organization embodying all hospital activity; therefore it is most appropriate that this twenty-fifth convention be given the distinction of *The American Hospital Conference* rather than that of an association meeting; and it is likewise fitting to travel again the road over which we have come, to review the work of these many years filled, as we know, with notable and worthy achievements.

On September 12, 1899 in the Colonial Hotel, Cleveland, O., four local hospital superintendeach from Ann Arbor, Mich., and Pittsburgh, Pa., gathered at the request of James S. Knowles, superintendent, Lakeside Hospital, Cleveland, Ohio, to form an association. The American Hospital convention, begun by those eight pioneers, attracted something like 3,000 visitors during its week's program last year. From 8 to 3,000, a growth of 37,000 per cent, is a mighty development, yet in a graphic way it expresses the development of hospital service in the United States and Canada.

One of the most interesting acts at the first meeting was a motion suggested by Mr. Clark, superintendent of the University Hospital, Ann Arbor, Mich., that membership be open to managers, i. e., those in charge of hospitals, irrespective of title and sex.

The first election of the association resulted in the following choices: Mr. Knowles, chairman, Mr. Clark, vice-chairman, Mr. Howell, secretary, Mr. Shaw treasurer; executive committee—Mr. Richardson, Mr. Howell and Mr. Clark. Membership committee, Mr. Putnam, Mr. Webber and J. C. Reiber, City Hospital, Cleveland. * * *

A study of the first constitution reveals the fact that the association was called "The Association of Hospital Superintendents," and its object was the meeting "of those in immediate charge of hospitals" for the interchange of ideas, discussion of hospital economics, inspection of hospitals, and suggestions of better plans of operation. Membership originally was restricted to executive officers of regularly organized hospitals.

There were twenty-two members present at the second convention (at Pittsburgh) and the idea of such an association had so wide an appeal that besides the institutions represented at the first meeting, hospitals from Philadelphia, New York, Brooklyn, Buffalo, Newark, Elizabeth, N. J., Atlantic City, Harrisburg, Lancaster, Rochester, and Warren, Pa., were present. * * *

The third meeting at the Murray Hill Hotel, New York, September 10-12, 1901, was welcomed by the Hon. Randolph Guggenheimer, president of the municipal council. * * *

Mayor Ashbridge welcomed the fourth annual conference of the "Association of Hospital Superintendents of the United States and Canada," as the organization now was known, at Philadelphia, October 14 to 16, 1902. The minutes say that 100 delegates and guests were present. * * *

The fifth annual conference at Cincinnati, October 20 to 22, 1903, was attended by fifty-nine

*Excerpt from the presidential address of Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill., read before the twenty-fifth annual convention of the American Hospital Association, Milwaukee, Wis., October 29, 1923.

visitors, among whom were Reuben O'Brien, E. S. Gilmore, Louise R. Curtis and Daniel D. Test, all of whom are still active. * * *

The sixth annual conference was held at Atlantic City, Sept. 21 to 23, 1904, at Hotel Rudolf, with sixty-one registered. * * *

The familiar "question box" first comes into the minutes of the association at this meeting. Dr. George H. M. Rowe was chairman. * * *

Constitution Revised—Name Changed

The revised constitution as adopted in September, 1904, changed the name of the association to "The Association of Hospital Superintendents," and provided for active membership for those "who at the time of their election are executive heads of the hospital without reference to sex, title or denomination. Honorary membership as of September 1904 showed 132 active members.

There were seventy-seven members registered at the seventh annual meeting at Boston, September 26 to 29, 1905. A feature of this meeting was a paper by Sir Henry C. Burdett of London on "The Hospital World." Another paper was on "The Standardization of Hospital Construction and Equipment," and on "Medical Libraries in Hospitals." * * *

Association Adopts Present Name

The eighth annual conference at Buffalo, September 18 to 21, 1906, had a registration of eighty-five. At this convention, provision was made for associate membership open to "such other persons occupying administrative positions in hospitals as are interested in the objects of this association and have been duly elected." A paper on "The Development of a Wider National Association," was read by Miss Aikens. This convention also passed a motion made by Dr. Rowe that "the name of this association shall be changed to the 'American Hospital Association.'"

* * *

First Commercial Exhibit in 1907

The ninth annual conference of "The American Hospital Association of the United States and Canada" as it was then known, was held at Chicago, September 17 to 20, 1907. The total registration was 146 and was generally representative of the hospitals of the United States and Canada. Miss Jane Addams of Hull House, Chicago, read a paper on "The Layman's View of Hospital Work Among the Poor." It was at this meeting that the first commercial exhibit was made under the supervision of Mr. Sutton.

The American Hospital Association first visited Canada at its tenth annual conference, September 29 to October 2, 1908, which was held in Toronto. By this time the program of the association had developed to such an extent that the standing committees included executive, membership, constitution and by-laws, auditing, nominating and committee on development of the association. There also was a committee on hospital progress. The registration at this convention was about 100. * * *

The eleventh annual convention was held at Washington, September 21 to 24. The patient's point of view entered into the program at this convention with a paper by Dr. W. Gilman Thompson of New York, N. Y., on "Hospitals from the Patient's Point of View." * * *

Another familiar subject that came up at this session was "The Hospital and the Patient of Moderate Means," which was discussed by Dr. Frederick Brush, superintendent, New York Post-Graduate Medical School and Hospital, New York, N. Y. The scope of the association was extended through the appointment of a committee on legislation.

St. Louis was the scene of the twelfth convention, September 20 to 23, 1910. At this convention first notice of exhibits was made in the minutes, President Howard calling attention to a non-commercial exhibit which was arranged by Miss Aikens. * * *

Training Administrators Advised

The training of hospital administrators first came to the notice of the association at this meeting also, a paper on this subject being prepared by Dr. Washburn and Dr. Howland. * * *

The thirteenth convention of the American Hospital Association was held in New York, N. Y., September 19 to 22, 1911. There was one session of this conference given over to hospital directors and trustees. The question of whether or not the annual conference should have an exhibit of equipment and supplies was one which received considerable attention and the convention authorized the president to appoint a committee on commercial exhibits. In the report of this committee toward the end of the convention it is interesting to note that the committee did not recommend that the association accept pay for the space for such exhibits. The report, however, noted the demand for an opportunity to inspect new appliances and equipment, especially by visitors who came to a meeting from a distance.

The non-commercial exhibits of this convention included displays from thirty-two hospitals, one of them from Manila, in addition to a large quantity of records and forms, and to seven exhibits of the work of social service departments in hospitals. * * *

Detroit was the scene of the fourteenth annual conference, the dates being September 24 to 27, 1912. A casual note in the brief minutes of the session of this convention indicates that this year saw the establishment of the commercial exhibits, which since then have grown to be one of the most practical and interesting features of the annual conferences. This meeting also was featured by the introduction of social service for discussion, with Miss Ida M. Cannon, Massachusetts General Hospital, taking a leading part. At this meeting the executive committee was authorized to have the association incorporated. * * *

At the fifteenth annual conference held in Boston, August 26 to 29, 1913, one full session was given over to nursing. At this convention the plan of holding section meetings was begun. Occupational therapy was introduced to the attention of the association in a paper by Dr. H. J. Hall on "Medical Workshops as a New Hospital Department." At this convention the scope of membership in the association was enlarged to include members of staffs and superintendents of nurses.

The sixteenth annual conference was held in St. Paul, August 25 to 27, 1914. A special feature was a report by the committee on the service the association might render members. A suggestion was made that the association should do more than merely hold an annual meeting; institutions were suggested, also a permanent secretary, an official organ and a suggestion towards standardization of supplies. The suggestion regarding the permanent secretary, however, was voted down when it was later presented in a resolution. * * *

Decide Upon Permanent Secretary

The seventeenth annual conference of the American Hospital Association, at San Francisco, June 22 to 25, 1915, was unusual in the fact that the ranking officer present was Miss Ida M. Barrett, third vice-president. * * *

Among the important acts of the association at this meeting were the appointment of the committee and the appropriation of $500 for a comprehensive commercial exhibit, and the adoption of a resolution that the association should have a permanent secretary. * * *

Philadelphia again was visited in 1916, September 26 to 29. An interesting feature of this meeting was the statement of the committee on development of the association, to the effect that it did not believe state associations were a move in the right direction. At this convention, a standing committee on out-patient work was recommended, and considerable revision was made in the constitution and by-laws. One change dealt with the method of application for membership, which up to this time was voted on by the association as a whole. The amendment gave the membership committee full power to pass on qualifications of applicants without taking up the time of the convention. Another important change was the creation of the board of trustees, of which the secretary of the association would serve as secretary. This amendment called for five trustees, who would have the general conduct of the affairs of the association "subject to the vote of the association," and who were required to make an annual report. An amendment also authorized the establishment of geographical sections. * * *

This convention also was distinguished by the first official activity of the American Hospital Association relative to the standardization program of the American College of Surgeons, the convention passing a resolution requesting the president to appoint a committee to co-operate with the college in its program. * * *

The nineteenth convention was held in Cleveland, September 11 to 14, 1917. * * *

System of President-elect Introduced

The secretary suggested that a president-elect be named at each convention in order to give the nominee an opportunity to familiarize himself with the work of the association before assuming charge. Other accomplishments pointed out by the secretary, Dr. William H. Walsh, in his report were the establishment of permanent headquarters and revision of business methods of the association, publication of bulletins, increase in membership and the establishment of bureau of registration and information. This meeting was featured by the first report of the board of trustees, which listed its activities during the year as including the appointment of a full-time secretary, determination to incorporate in the District of Columbia, inauguration of a system of membership censorship, and a membership campaign. * * *

The entry of the United States into war during the spring of 1917 had its effect on the program for this year. A resolution was passed expressing the desire of the Hospital Association to cooperate to the greatest possible extent with the military authorities and with the national Red Cross, and suggesting that a competent hospital administrator be made a member of the National Council of Defense.

Institution membership was authorized at the

twentieth conference of the association, at Atlantic City, September 24 to 28, 1918. * * *

First Daily Bulletin in 1919

An out-standing feature of the twenty-first annual conference at Cincinnati, Ohio, September 8 to 12, 1919, was the appearance of the daily convention bulletin. A joint meeting of the American Conference on Hospital Service and the association, and the American Dietetic Association and the association were high spots of this convention. * * *

The twenty-second annual conference, held in Montreal, October 4 to 8, 1920, was featured by the appearance of the first convention service bureau, which was in the nature of an advisory committee, whose members were available for advice, assistance and information by all desiring such. * * *

The report of the trustees was presented by Dr. A. R. Warner, the new executive secretary, and included the notice of the closing of the Washington office and the establishment of the present office in Chicago. This report contained the authorization by the trustees of the establishment of state hospital associations as geographical sections of the American Hospital Association, and the creation of an associate institutional membership. The Ohio and Wisconsin Associations were formally admitted as the first geographical section, and the trustees during the year reported that they had approved participation in the organization of the Hospital Library and Service Bureau, established by the American Conference on Hospital Service. The trustees also reported that application had been made with the Secretary of State of Illinois for incorporation.

The importance of food service in hospitals was formally recognized by the association at its twenty-third convention, at West Baden, September 25 to 30, 1921. At this meeting the first program of the section on dietetics was given. The scope of the service rendered by the association has been enlarged during the year by the establishment of a service bureau on hospital social service work, and service at the convention was increased by special committees on flooring, on relations between hospitals and cities and states, and on hospital records. * * *

The Colorado, Indiana and Michigan Associations were admitted as geographical sections of the association. * * *

The twenty-fourth annual convention, at Atlantic City, September 25 to 28, 1922, indicated that the American Hospital Association had progressed to such an extent that hotel conventions no longer were possible. Because of the popularity and steady growth of the exposition of hospital equipment and supplies, the space required for this department in 1922 made it necessary for the association to lease the million-dollar pier. According to the proceedings, the total attendance at this conference, including all persons given official badges, exceeded 3,000. Missouri, Pennsylvania and New England were added to the geographical sections this year. The first formal meeting of the section for trustees was held at this time. * * *

A big feature was the election of a president-elect nominated from the floor. Such action was authorized by the trustees during the year, and the first man accorded this honor was Dr. M. T. MacEachern, then superintendent of the Vancouver General Hospital, Vancouver, B. C. * * *

A comparison of the program of this convention which marked the closing of the twenty-fourth year of the association, with the program of the first convention, indicates in a striking way the development of the hospital field. There were nine present at Cleveland, and more than 3,000 at Atlantic City at the twenty-fourth convention. The first convention held four sessions in two days, while the twenty-fourth met fourteen times in four days. Three states were represented in 1899, in 1922, thirty-eight states, the District of Columbia and three Canadian provinces. While there were no references, even to hospital equipment at the first convention, the twenty-fourth session represented an expenditure of more than $100,000 by the manufacturers and distributors in the hospital field, who were anxious to show the association the equipment and supplies, and in addition there were seventeen displays and booths of an educational nature by non-commercial organizations, while half a dozen journals dealing with the hospitals and allied fields had exhibits.

Such, in brief, is the story of the development of the idea which was originated by Mr. Knowles in Cleveland twenty-five years ago. Only two are left of the seven hospital superintendents who shared his views for an active association, but the idea which they inaugurated so informally has steadily grown year by year, until today its effect is shown in the steadily improving care and service which the hospitals of the United States and Canada are rendering to the hundreds of thousands of sick and afflicted. * * *

Our association has been faithful throughout the years to the highest standards it was possible to conceive and apply, therefore, it is good to see the faithful recognition of these ideals during the past years develop the organization into greater

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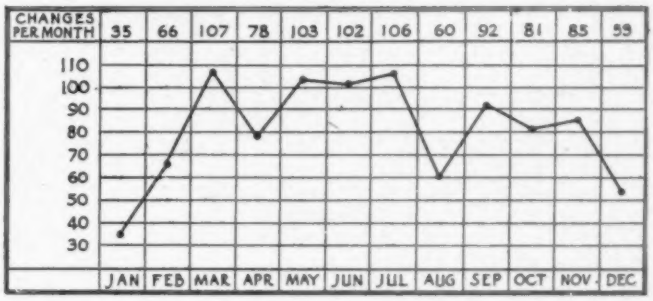
SOME CAUSES OF LABOR TURNOVER IN HOSPITALS*

By CHARLES F. NEERGAARD, New York, N. Y.

AN EDITORIAL in the August issue of THE MODERN HOSPITAL, in referring to the labor turnover in hospitals concluded with the following: "The subject is important enough to warrant some extensive study to determine just what the loss occasioned by labor turnover among hospitals of this country is, and what measures can be taken to bring it down to an irreducible minimum."

The subject is deserving of extensive study, for hospitals have unquestionably lost thousands of dollars from the excessive cost required to maintain the quota of personnel needed. The extent of the loss can be surmised from the fact that in the General Electric Company in 1912, the cost of firing a man, and hiring another to fill the same position was found to average $53.92, and that was before prices, in general, began to rise. However, it is not intended to discuss the expense of labor turnover now, but the reasons and the possible measures for retaining employees.

The editorial quoted states that in a mid-western hospital for the first six months of 1923, there were 293 changes of which 190 left voluntarily as follows:



No reason given	75	38.9%
Left for higher pay	28	14.5%
Work too hard	28	14.5%
Shifters	27	13.9%
Dissatisfied with working conditions	20	10.4%
Sickness	8	6.2%
Married	3	
Died	1	

Perhaps these figures tell the story of labor turnover in many hospitals, but what is the matter with the wages and working conditions, and why is the work too hard?

A study of three representative hospitals of New York City, helps to answer these questions. Hospital "A" is composed of remodeled dwellings with very inconvenient arrangement, inadequate space, varying floor levels, many stairways and ramps; the nurses' home is a renovated tenement house of six stories and no elevator, with few private rooms for the nurses and most of them dark. The equipment of the hospital is inadequate and old, the utility and bath rooms are combined. The housing facilities for employees are very poor, and the food poor in service but perhaps average in quality.

Hospital "B" is composed of modern buildings well planned but widely spread out, the equipment modern and adequate, the housing and food for employees, above the average.

Hospital "C" is exceptionally well planned, compact and well equipped, the housing facilities and food for nurses and employees considerably above the average—really excellent.

Turnover for 1922

Considering the number of positions involved in the problem of labor turnover and the labor flux (total positions divided into total number of persons required to maintain quota) we give below statistics for the year 1922.

There are several factors which deserve consideration in explaining the labor flux. Wages were the reasons for at least 14.5 per cent of the employees leaving the mid-western hospital referred to above. The National Industrial Conference Board determined in 1919 that an amount of $1,267.76 was required for a family of five, but how many hospitals know whether a new employee is married or how many dependents there are? The Minimum Wage Board of the District of Columbia made a study of 2,209 cases of women employed in the district. In that report (page 6) the cost of room and board for a self-supporting woman as given by the Conference on the Printing and Publishing Industry, at $9.00 per week, and by the Mercantile Conference at $9.30 per week, are taken as a basis, and the $16 a week or $69.44 a month, the minimum wage required.

	Hospitals		
	A	B	C
Total persons employed	587	598	202
Number of positions	165	229	86
Labor flux	3.55	2.61	2.34

This study by the Minimum Wage Board showed the percentage of women employed in various establishments who were receiving less than $16 a week to be as follows:

Restaurants	42.6%

*The facts contained in this article are not presented as conclusive but are merely given as a basis of comparison for hospital administrators and workers.

Hotels	72.2%
Hospitals	82.3%
Apartment houses	100%

This is a partial explanation of why hospitals have a considerable problem in labor turnover.

Taking fifteen identical positions in each of the three hospitals, the average wage per month was "A"—$97.80, "B"—$77.33, and "C"—$75.36. These positions included administrative as well as minor positions.

The wages paid to maids and porters in "A" were $35 a month with room and board, or $50 without; "B" $32 with room and board, or $40 without; and "C" $50, to $45 with room and board and $50 to $55 if they lived out. The majority of those living out had at least one meal in the hospital. Apparently the wage was not the determining factor.

The same study by the Minimum Wage Board disclosed discrepancies in the allowance made for board and room, in the case of the three hospitals studied "A" allows $15 for living out or, looking at it the other way, considers the cost of board and room outside the hospital at $15, while "B" and "C" allow only from $8 to $10. Even the relatively fair salary paid by "A" and the generous allowance paid for living outside the hospital were not sufficient to hold employees.

An examination of the quarters provided for employees in the three hospitals showed "A" to have poor facilities, while "B" and "C" had excellent accommodations. The two hospitals, however, which had excellent accommodations showed a surprisingly close relation between the percentage of employees in each department who lived in, and the labor flux, while hospital "A" showed just the reverse.

Hospital "B"	Living In, Per Cent	Labor Flux, Per Cent
Graduate nurses	100	1.51
Orderlies and aids	55	2.66
Kitchen and storeroom	41	3.19
Housekeeping department	24	3.83
Laundry	20	3.45
Hospital "C"	Living In, Per Cent	Labor Flux, Per Cent
Housekeeping	82	2.30
Laundry	80	2.10
Kitchen and storeroom	80	2.20
Graduate nurses	80	2.30
Orderlies and aids	66	3.00
Hospital "A"	Living In, Per Cent	Labor Flux, Per Cent
Graduate nurses	84	3.92
Orderlies and aids	73	3.84
Housekeeping	64	3.66
Kitchen	0.0	3.20
Laundry (very poor facilities)	0.0	5.00

Wages—Not a Determining Factor

From this limited study it is apparent that there is a definite relation between the labor flux and the conditions for living and working. It is also shown that the hospital which has poor rooms and meals to offer employees will have less labor trouble, if the employees are allowed to live outside the hospital. Furthermore, wages do not appear to be the determining factor in retaining employees.

Can it be denied from the limited material at hand, and perhaps it is sufficient, that the labor flux can be brought to an irreducible minimum when we consider the following:

PERTINENT FACTORS—Hospitals	A	B	C
Labor flux	3.55	2.61	2.34
Bed capacity of hospital	168	294	100
Per cent utilization of beds	81%	71%	93%
Per diem cost of all patients	$5.55	$5.33	$6.77
Average wage—15 positions	$97.80	$77.33	$75.66
Housing rating	Very poor	Excellent	Excellent
Food rating	Average	Excellent	Excellent
No. employees per patient	1.18	1.6	1.3
No. patients per nurse	2.47	1.6	1.86
Monthly compensation to pupil nurses	$25.00	$10.00	$10.00
Equipment rating	Very poor	Good	Excellent
Arrangement of hospital	Very poor	Good	Excellent
Labor incentives	None	None	None

If the data is sufficient, it can be stated dogmatically that to reduce the labor turnover, avoid the standards of hospital "A", and aim for the standards of hospital "C": Give your employees comfortable rooms, good food, keep down the ratio of employees to patients, and the ratio of patients to nurses, provide the necessary equipment, have the hospital building planned so that nurses and help can do their work without waste effort, don't expect too much from increasing the wages, but pay a good living wage and make fair compensation for those who live out.

Judging from the seasonal changes which occurred in the three hospitals studied, it might be wise to serve somewhat better meals to employees during the spring months and to give wage increases the first of the year if you want to keep them.

Another recent study of labor turnover in a New York hospital showed a very high rate of flux and that most of the changes occured before the employees had worked three months. To obviate this a wage increase was promised to the new employee after three months service. This plan decreased the turnover appreciably. Labor incentives in the form of wage increases for continued service and a system of pensions might well prove a good investment.

The treatment of employees in hospitals has not kept pace with the treatment accorded in other establishments, and a thorough study of hospital labor problems would doubtless give information that would mean an enormous saving to the hospitals of this country, and a great satisfaction to the employees.

CONSTRUCTING HOSPITALS FOR THE MENTALLY DISEASED*

By SAMUEL W. HAMILTON, M.D., Divisional Director, National Committee for Mental Hygiene, New York, N. Y.

AFTER the recent fire in the Manhattan State Hospital, resulting in the loss of twenty-seven lives, great popular interest was displayed in one phase of the construction of hospitals for mental patients—fire hazard. That the employees on duty in this case did not lack faithfulness is plain on the face of the record—three of them perished in the fire. To those who have administered such institutions this subject is not new but always of vital interest, as a conflagration is always to be feared.

To Replace Tinder-Boxes

It is hoped that the stimulus of public sentiment will effect into the hands of trustees and boards of construction delivery of the large sums necessary to replace the numerous tinder-boxes which house mental patients. Because of the enormous increase of hospital population during the last three decades coincident with improvement of standards of care in the hospitals and the trend of general population to the cities, such replacement has rarely been attempted. As fast as new buildings are ready, they are filled merely from the excess in the older structures. Nevertheless, if the problem of an adequate building program is once faced, it can be solved. The extensive literature on surgical and tuberculosis hospitals of the last few years has not been equalled in amount or value by parallel discussions of buildings for mental cases, and it is our purpose here to offer a few constructive suggestions on the principles involved and on errors to be avoided in planning such buildings.

A battlemented tower out of harmony with rest of building; usefulness of third floor impaired by low roof.

Problems Peculiar to Mental Hospitals

Most of the principles of good hospital construction for other types of sick persons apply equally to institutions for mental diseases, but because of the conduct of such patients there are certain special difficulties in relation to this work that call for modification of plans elsewhere used. Let us cite a few instances. Take the question of privacy. As a rule we wish to give the patients in general hospitals the greatest degree of privacy that is consistent with economy.

In mental hospitals, on the other hand, there are many patients who are hyperactive and mischievous; there must not be too many corners in which they can hide; their distractibility leads them to deface walls and displace small articles of use or ornament and often to break pieces of furniture or plumbing installations, all on the spur of the moment. Some confused patients, without a definite purpose to do so, may injure themselves severely, if not prevented by a vigilant nurse; and there are suicidal patients who must be under observation every minute lest they commit an act which will jeopardize their lives. Some patients whose conduct is not marked by the abnormalities just mentioned must have a restricted degree of privacy, because when not observed they tend to defile themselves or their surroundings or do other things indicative of inner conflicts in which the tendency to undesirable conduct gets the upper hand. There are also irascible patients; provision must be made so that these can be constantly under observation in order to prevent their flying into a rage which will be difficult to quell.

Architectural Ingenuity Required

A few must have individual rooms so constructed that there is little that can be damaged and large enough so that the patient can work off his bad temper by walking about, thereby giving utterance to his disagreeable thoughts as loudly as he will but without disturbing others. In order

*This is the first of a series of articles by Dr. Hamilton on the construction of state hospitals.

Two stairways leading to the same point.

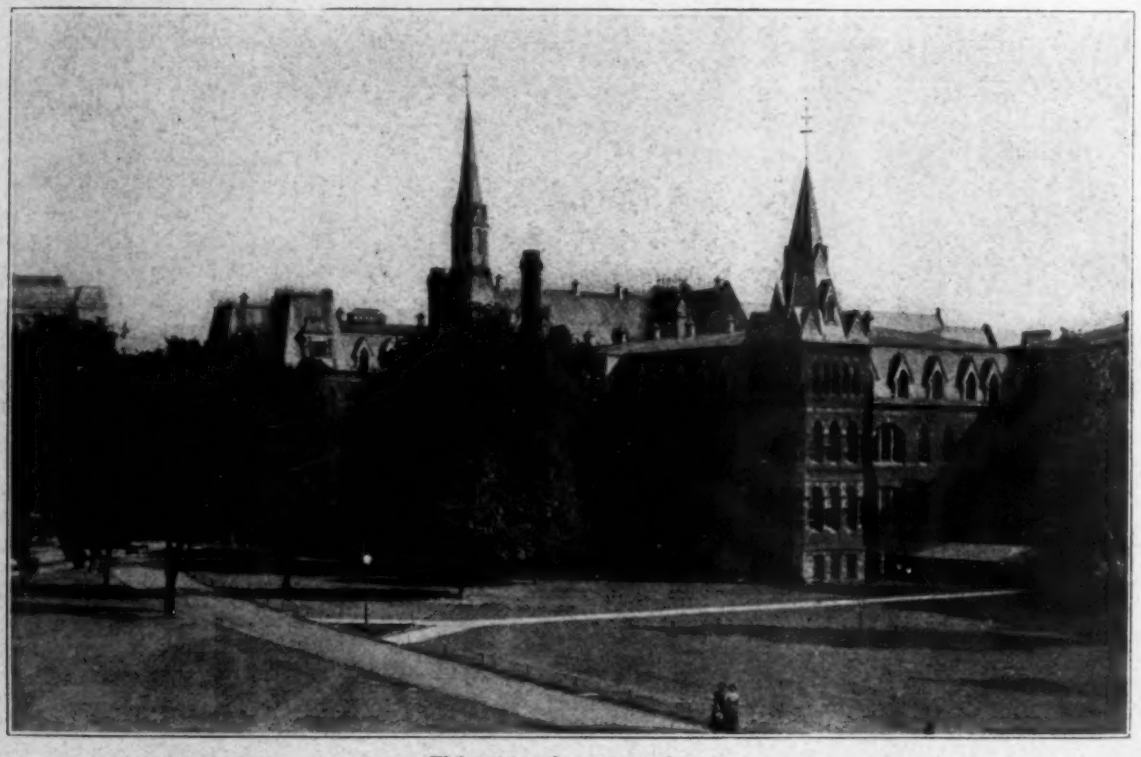
to arrange a room to meet these requirements and yet be cheerful and not prison-like, no little architectural ingenuity is required. Again, most of the unskilled labor of a hospital for mental diseases is done by patients. Some of them work as skillfuly as a paid employee but many of them are handicapped laborers, two or three together accomplishing only as much as one normal person would, so that such places as laundries, diet kitchens, and vegetable rooms need to be of more generous proportions than in the ordinary general hospital.

15,000 New Beds Needed

A psychiatrist with long experience as superintendent of several institutions and as head of an important state system has remarked that if the money spent on building projects were wisely spent, all the legitimate structural needs of the insane would be met. When one recalls that 15,000 new beds are needed today in the United States this statement may seem rash, but a study of buildings now in use tends to confirm his opinion.

Cottage Plan of Housing

During the Middle Ages the insane who could not be cared for at home and did not spend their troubled lives in prison or in wandering about the land were cared for in monasteries. It was natural, therefore, that the ecclesiastical types of architecture should be copied when special institutions for the insane were first erected in this country. Classical models sometimes were preferred to Gothic, but height was thought a virtue, whatever the style. Our older buildings are stately structures rising to the height of several stories in the administration section and sometimes quartering patients as high as four stories from the ground.



Elaborate roof ornamentation.

During the last thirty years another tendency in hospital planning has prevailed and the cottage system so-called has been accepted as a more desirable plan for a mental hospital. The term "cottage" in this connection is perhaps a misnomer as it generally denotes a building holding

as many as a hundred patients. At any rate, detached structures are the rule now and in institutions whose builders are able to follow their ideas of what is best in plan and structure, such buildings are small enough so that patients can be assured of individual attention and a considerable degree of comfort. Unfortunately, during the last three decades, the number of patients in institutions for mental diseases has increased enormously. The resultant economic pressure has driven many states to build larger structures again, and even in some of which have the most progressive policy in such matters, one can see large recently-erected buildings with quarters for patients on the third floor.

Architectural Needs of Mental Patients

The architectural needs of hospital patients may be summed up as light, air, warmth, a measure of privacy for those who respond to the stimulus of privilege, opportunity for work and exercise, a quiet appeal to the esthetic sense, and accessibility to places where food is served, diversion afforded, medical examinations made, and various forms of treatment given. There is justification of a recent remark in the *Architectural Forum*: "Such hospitals have not ben standardized to the same extent as other types, and it is difficult to find many good examples."* Few architects have opportunity to plan buildings for mental patients and it is to be expected that they will encounter difficulties in approaching such a problem. In a few commonwealths a state architect may hold office several years, acquire a considerable fund of information about the needs of such institutions and design buildings which are in all regards admirable. Some such officials are less open to advice than one might wish.

Elaborate set of steps to reach door. Base and large part of shaft of pillars are concealed from view.

Practical Lines Sacrificed to Beauty

An architect may be admirably equipped for other types of construction, but the building of garages, libraries and even apartment houses does not enable him to design a good building for disturbed mental patients. It is no reflection on his general ability that he is not prepared to plan such a building, but it should be obvious that every detail should be planned in close cooperation with medical men who know the problems of conduct

Simple but pleasing lines.

*Vol. XXXVII, No. 4, p. 246.

Unguarded stairway marring the appearance of a sitting room.

with which the hospital must cope; otherwise there is danger that even a durable and attractive building may not function well. However, some excellent building plans have come from architects who have compensated for lack of specific experience by studying existing buildings and conferring with their administrators.

Tiny laundry for institution of 1,800 patients.

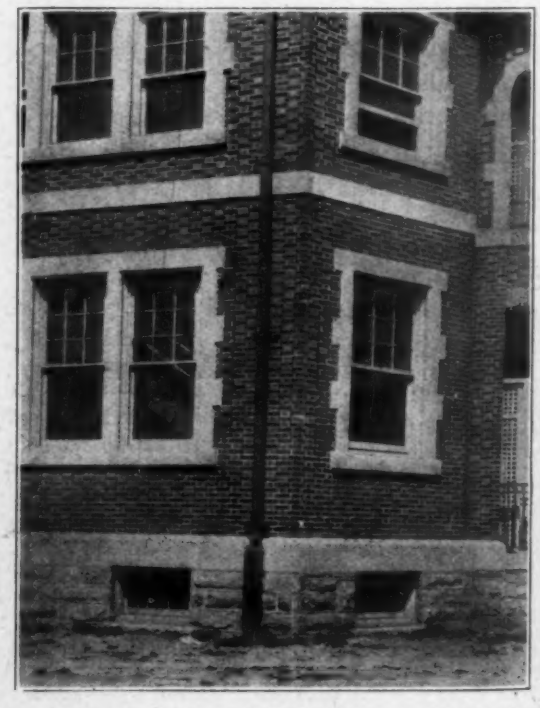
Practical Lines Sacrificed to Beauty

Another tendency must be guarded against. Institution builders often tend unconsciously to plan and construct buildings that will be monuments to the builder. Since public funds are never excessive and often hardly adequate, plainness of line and severity in detail are necessary in order to make provision for the number of patients to be housed. It is regrettably true that some buildings have widely departed from this principle. Practical lines and essential conveniences are sometimes sacrificed in order that a building may be beautiful and stately, under the specious plea that any public building should reflect the dignity of the commonwealth that erects it. It is vastly more important to have the building serve the patient's need than preserve the building committee's memory.

Salient Features of Construction

Let us note some of the ways in which there is lack of economy:

1. The plan of the building may involve the use of an unnecessary amount of material. One sees buildings with many external angles which increase the cost of material and the cost of labor. Roof lines are broken in such a way that additional valleys must be laid. Projections of strange and meaningless style, turret-like effects on buildings which are never to be used as military defenses, and other departures from simple lines add to the cost without adding much to the beauty or anything to the utility of the building. Six pillars are placed where three would do, and four take the place of two. A two-story building has twenty-four inch walls. Two stairways are run from one floor to the next, starting from almost the same point and ending but a few feet from each other, the purpose alleged being to balance the entrance. Or poor planning is ultimately costly because no sooner is the building in use than it must be changed. Service sections are too small, dining rooms, inadequate. Laundries are rarely allotted sufficient floor space so that the working patients of a hospital for mental diseases will be comfortable during the intervals between their periods of work. Sewers are laid at too slight an angle and have to be dug up when stopped



Big, costly panes of glass and different sizes, not standardized.

and pipes are brought long distances without being enclosed in tunnels thereby suffering corrosion.

2. Materials are sometimes chosen more with an eye to the individual taste of the architect or some trustee than to economy of quarrying and transportation. Building materials that can be obtained in the neighborhood are rejected and others brought from a distance; a certain state hospital makes excellent bricks but these cannot be used on the exterior of its new buildings because the older ones were faced with brick from another neighborhood. Cement floors are laid over beams that are sure to shrink and cause cracks. Stairs are made of soft stone and wooden stairs are not protected by metal treads and rapidly wear out. Flashings are not made adequately wide for the climate or else are of material which breaks when put to the strain of varying temperature, with the result that interior walls are destroyed by penetrating moisture and must be repaired at considerable expense. Huge panes of glass are put in places where the liability of destruction is considerable.

Exposed steam pipes, offering risk of burns and of suicide by hanging.

Utilization of ground levels.

Artificial plateau.

3. Expensive fittings are used in place of ones that would be cheaper and quite as useful. A great deal of money is wasted on hardware. A certain building, for instance, is supplied throughout with thirteen dollar locks, whereas a six dollar type would be easier to operate and less inclined to get out of repair. Spring locks have been put on windows and so located behind guards that it was impossible to operate them without a difficult manipulation of curtain, window guard, and furniture standing in the neighborhood. Three thousand feet of corridor have been faced with enameled bricks at three for a dollar, although

less costly material would have been quite as useful and more appropriate to the structure.

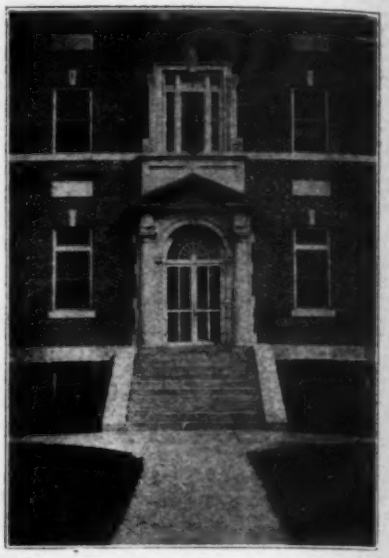
4. The utilization of ground levels is not always well done. Sometimes an architect creates a plateau for his buildings instead of placing them on different levels in accordance with the lay of the land. When the time comes for the erection of an additional building, a vast amount of dirt must be hauled from a considerable distance to extend the plateau or else the whole system of drainage and heating must be revised.

5. Buildings are badly located as regards heat, light, supplies, and food. Obviously such matters should receive careful attention before any construction is done. Institutions for mental diseases have a large supply of unskilled labor in their working patients, consequently expenses due to such poor arrangements may be largely covered up by the number of patients that fetch and carry, but if lines of transportation are well planned this labor is released for other important purposes.

6. The standardization of supplies for repairs and avoidance of causes for replacements are not always considered. Five different sizes of window glass may be installed in the same building, which means that five sizes must be carried in stock. Steam pipes are often run through sitting rooms, dormitories and bed rooms, so that patients are liable to be burned; when these pipes are covered with asbestos, the danger of injury is lessened, but there are many mischievous patients who are only too likely to destroy this insulation, causing the loss of the cost of its renewal as well as reviving peril to all those about. Elaborate plumbing is left exposed, so that a restless patient can do a vast amount of damage by wrenching it loose.

Stairwell inviting depressed patients to jump down headlong.

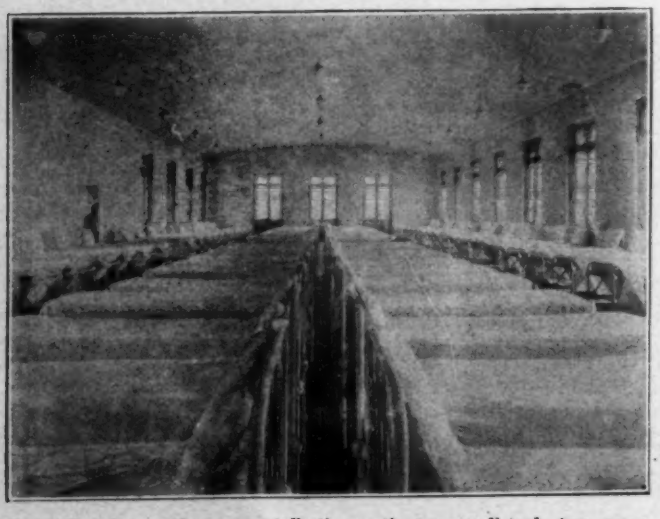
Some of the things mentioned above are reflected in a high first cost of building. Others result in the need of changes which lead to an unnecessary expense after the building is already up, while others result in expenditures for extra labor scattered over the entire life of the building, which may be scores of years.



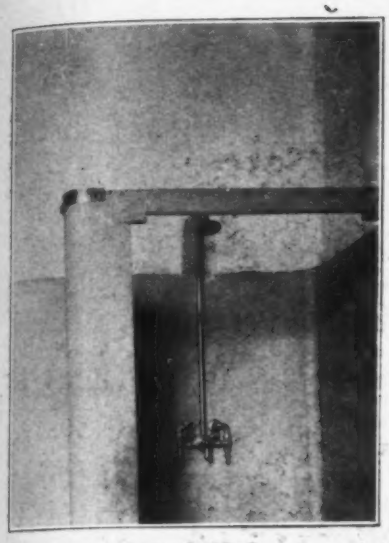
This is the only porch on a building for 160 patients.

Poor planning leads to other difficulties which cannot be said to cast actual money either at the time of construction or later but which make the administration of the building unsatisfactory, thereby adding to the labor of the personnel and lessening the comfort of the patients.

Employees' quarters have been placed directly across the hall from the patients. Now even the most industrious patients may occasionally talk to themselves, and during the night there is always the likelihood that someone will go about and as he goes slam the door behind him. Attendants, therefore, who have worked hard all day are disturbed once or many times during the night. It is not only a hardship to them but a cause of resignations detrimental to the institution which had started out to fit the attendant for skillful service. Enormous dormitories are erected with beds for a hundred or more patients in one room. To be sure, observation of patients should be made easy at night, so that the nurse or attendant on duty can tell exactly what is going on without disturbing the patients who are asleep, but in huge dormitories like this the liability to disturbance is very much increased and more than one patient has complained because he was put in a big room with so many others that someone was sure to be moving about during every



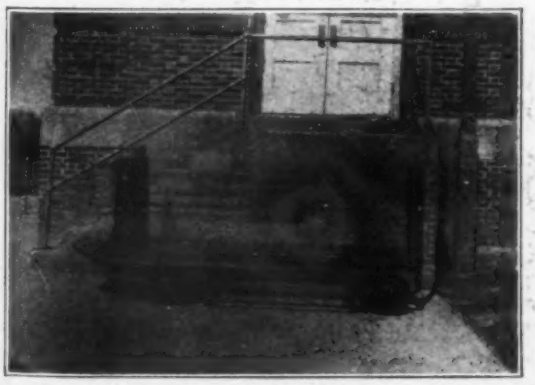
Huge dormitory where one talkative patient may disturb two score.



Spray bath, control apparatus out of reach of attendant.

hour of the night.

Pipes are run through sitting and bed rooms and angulated near the ceiling—a wonderful place from which to hang. Stairways are so constructed that there is a well two or three stories high tempting a depressed patient to jump over. Stairways are left open above and below so that restless patients can go up and down as they will and all sounds from one floor may reach the other. The prison idea sometimes affects hospital plans. Buildings housing a large number of patients are provided with tiny porches, if any at all. Dining rooms for physicians and nurses are so placed that they can be reached only through a kitchen. In certain buildings the attendants' quarters have window sills four feet up from the floor so that the occupant, unless he stands up, can see nothing but the sky. The outside approach to a door has been known to have a smooth cement surface, extremely slippery when snow lies on it, and somewhat dangerous even from rain or scrub water.



High stoop to which food containers must be lifted from truck, and then up still another step to reach floor level of serving room.

Corridors are often long, dark and gloomy because single rooms stand on each side in unbroken rank. Food containers must be lifted up and down stairs on their way to and from the kitchen instead of being swung onto and off their trucks always at the same level. Spray bath apparatus has been so installed that it could be operated only by the bather, a most dangerous procedure. Again, patients leaving a ward to be bathed must sometimes go through a dining room or a visitors' reception room. Two sets of keys have been made for one building, so that every one must carry one style in order to get in and out and another style to pass from room to room. In these and other ways, conditions are created which are a detriment to the institution and no credit to the one that plans it. They are usually due to ignorance and lack of study of problems involved and occasionally due to the stubborn temper of the person who has the last word on what shall be done.

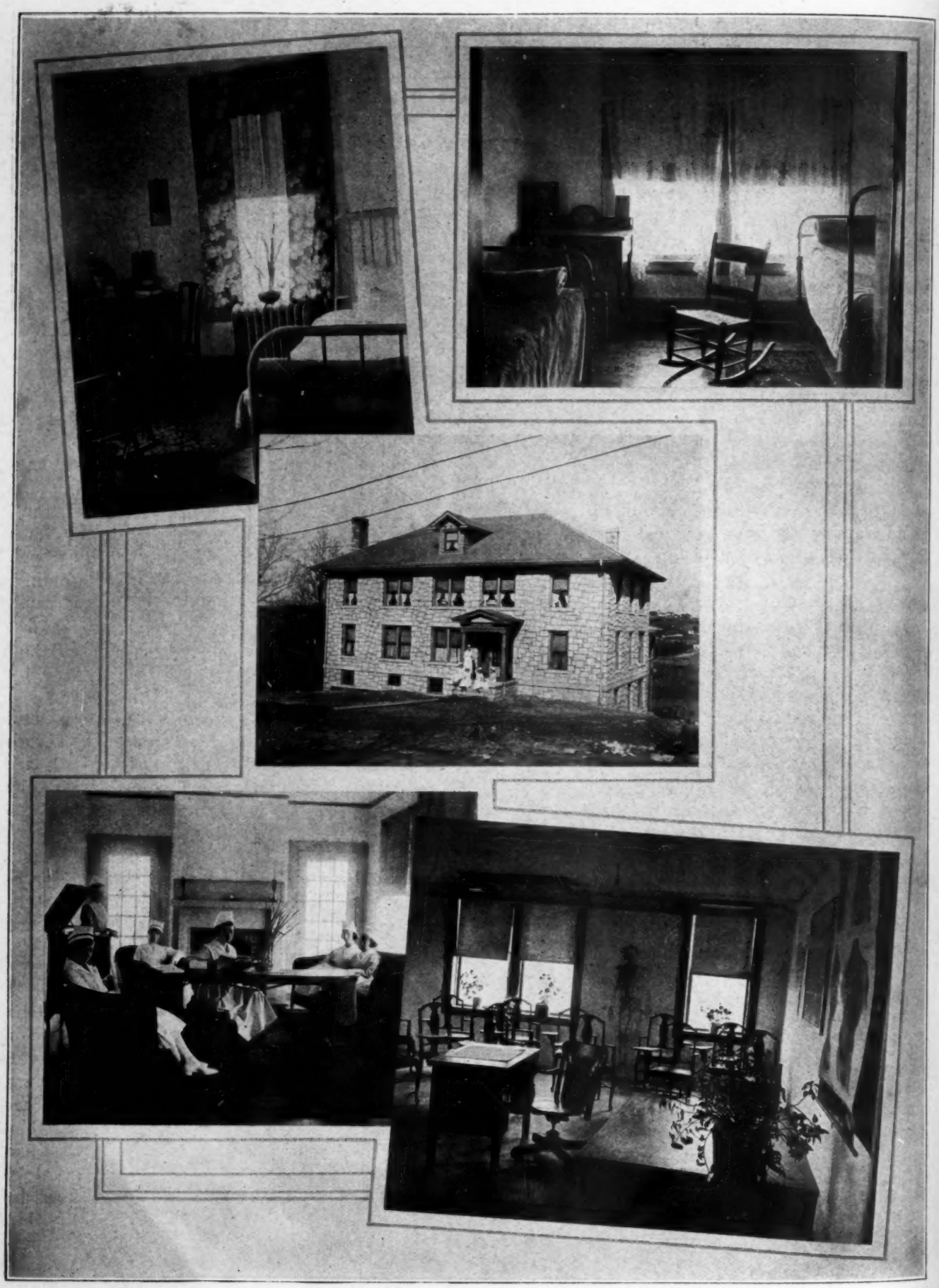
Long corridor, lighted only indirectly.

Employees' room with window four and one-half feet from the floor.

Purpose of Series

We hope in this series to give brief descriptions of some of the newer buildings in hospitals for mental diseases. Such buildings have been planned with sound principles in mind, and we intend to indicate in a measure wherein the accomplishment is strong and wherein it is feeble. It is not the intention to find fault with what has been done except as that may be incidental to pointing out what desirable features may be adopted from an existing building in order that the next one of the same style may be nearer perfect.

MARTIN MEMORIAL HOSPITAL NURSES' HOME, MT. AIRY, N. C.



PUBLICITY THROUGH BOOKLETS AND LEAFLETS*

By RALPH WELLES KEELER, Counsellor in Publicity, Board of Hospitals and Homes of the Methodist Episcopal Church, New York, N. Y.

PRINTED publicity can never be too good. Yet the printed matter sent out by a hospital for purpose of information or propaganda often reflects disadvantageously upon the institution represented. This may not always be due to the inferior quality of the material. It may be due to the fact that comparison with the best always draws attention to the weak points. And the comparisons of this sort are very generally made today. For never in the history of printing has there been sent out so many booklets and leaflets to set forth the claims of causes and institutions as they are today.

As the hospital is assuming its place as a public utility, it must be "sold" to the public in the same way that any commodity is "sold". Since printed matter issued by the hospital is the salesman of its services, it is important that this agent of the institution should present selling points in the most interesting and convincing way. It is just as absurd for a hospital to print as its publicity the same general uninteresting facts year after year as it is for the advertiser of a modern electrical device to use antiquated or hackneyed selling talks. Yet some hospitals never direct to public attention anything but a booklet of printed facts so general in character that it could be used for any hospital at any time.

Yet many hospitals have failed to take a page from the experience of business houses. Some continue to prepare and distribute amateur "literature," and then wonder at the lack of results.

It is well, therefore, at the very beginning of any plan for booklet or leaflet publicity, to consider a number of things carefully. In the first place no booklet or leaflet should be gotten out just for the sake of getting something printed or keeping someone busy. In studying the entire scheme of the hospital's publicity, it is possible to determine just what pieces of literature are needed. This conclusion will be reached in a satisfactory way only by considering at the same time the message that should go out and the people to whom it should be sent.

How the Publicity Survey Helps

Enough has been said in previous articles to indicate the necessity of both the publicity survey and the picture possibilities survey. For without these the one charged with publicity tasks must forever be rushing through the hospital to find this or that for immediate use. Also, in getting ready for the planning and preparation of booklet and leaflet publicity, the files of publicity already prepared and sent out and of available photographic material are of great value. It is of first importance that everything done should be fresh and up-to-date and presented in a little different way from anything already given to the public. This does not mean that the same fact may not be used over and over again. It does mean, though, that each time the same facts or figures are used they should be put in a word setting that gives them a certain newness of appearance and interest.

While every hospital has certain features peculiar to the institution, ones which lend themselves to booklet and leaflet publicity, there are a few types of this form of propaganda that are both necessary and useful to every hospital in its task of keeping the public informed and interested in a practical and concrete way in its work and needs. Some of these may not appeal to those superintendents anxious for some large immediate response. But to those who are concerned not only with immediate returns, but who also desire to lay broad educational foundations for the returns that will come in the months and years ahead, the booklets and leaflets here mentioned will be of inestimable value. The relative value of the several pieces of literature suggested will depend in part on the way they are used. Each, however, has a very definite usefulness in the whole process of getting the information to the people whom it is desired to reach and in such form that they will wish to read it.

Booklets and leaflets on the work of a hospital must be written and printed in an attractive way to insure reading. The use of blue ink on pink paper gives the one receiving it a distinct shock. Booklets written in sermonic style are laid aside after the first paragraph is read. Narrow margins and small type offend the reader. Pictures out of focus or wooden in their composition receive only a glance.

There are so many things entering into the make-up of a booklet or leaflet which either send it on as a successful messenger of the hospital or else doom it to one of the many waste-baskets kept for such material, that too great care cannot

*This is the seventh of a series of articles on hospital publicity prepared for The Modern Hospital by Mr. Keeler.

be exercised at every step of the way in conceiving and getting such literature printed. It is well to save printed matter received from a variety of places. Visit the food and electric shows and get their booklets and leaflets. Write to some of the national advertisers for their literature. Do not be above taking suggestions from the way others are presenting what they want the public to know. And never decide that because a certain form of printed presentation does not appeal to you that it will not appeal to others. There are many who do not like most of the "movies" that are now before the public, but the "movie" houses are crowded and the box office receipts render good returns on the money invested. National advertisers have experimented at great cost to discover the kind of printed matter that gets results. Therefore their literature is an excellent text-book on the whole subject.

The History Booklet

A booklet, three and seven-eighths by seven inches, trim, type page three by five and three-quarters, sixteen pages, should be prepared, giving a brief history of the hospital, together with the growth and development and enough statistics to emphasize this growth in a concrete way. It could be on an India tint coated paper, heavy enough to give the booklet sufficient body so as not to be flimsy. Pictures of the buildings from the beginning should be printed, and the story itself written in a "racy" style. In this brief history, the purpose of the hospital and the method of financing it should be incorporated; also the rates charged patients of all classes. An attractive line cut illustrating some phase of the work of the hospital would liven up the cover, and the cover might also bear some title such as "From 1889 to Now—."

The Descriptive Booklet

A descriptive booklet, "A Trip Through Mt. Sinai," (of course using the name of your own hospital) is the second of what may be called the permanent pieces of literature. This could well be either five by seven and one half inches or six by nine inches, the former perhaps being the more convenient size. It should have a cover of heavier stock than the pages carrying the text. The inside stock should be good enough to carry engravings well. A good type to use would be eight or ten point, and if funds are plentiful it could be printed in two colors. If only one color is used, an India tint coated stock with a double-tone brown ink makes a good combination and brings out the half-tones with excellent effect.

In order to determine the story that should be the content of this booklet, map out the progress of a surgical patient from the time he writes, or his doctor applies, for his admission. By following him through the entire process of his reception from the ambulance, x-ray and other examinations, preparation, anesthetizing, operation, days in the ward in bed, convalescence, and final discharge there is opportunity for playing up the entire work of the hospital. For while his case illustrates only the surgical procedure, during his convalescence he may become acquainted with the procedure with the sick and departments for children and other special types of patients.

By outlining this procedure it will be seen that the work of the administrative staff, surgeons, nurses, ambulance driver, and interns, dietitians, x-ray specialists, laboratory chemists, butchers, baker and everyone gives a part to the story. Once the outline is determined upon, study the photographic possibilities. For this booklet should be profusely illustrated with live, compelling pictures. And each picture should be of such character as to tell its own story so that captions will not be needed. This makes possible placing the picture in the text at the place where reference is made to it.

The cover can be illustrated. A bleeding halftone of the front entrance with some one going up the steps is effective. So, too, would be a bleeding half tone of a view down a corridor or a ward. If the corridor is used, have some person or persons in the background of the illustration.

The Condensed Annual Report

Brief mention of the use of a "racily written" condensed annual report was made in a previous article. This should be six by nine inches self cover and on good paper. It can be reduced to sixteen pages including cover and should be printed in eight or ten point type. The type used by THE MODERN HOSPITAL for this article is a good example to follow, including the heading and subheadings. This condensed report should aim to comprehend all that appears in the fuller annual report. But the material should be carefully digested by the writer so that it is an entirely new creation. It should also be written from the viewpoint that the reader has never heard of the institution, and such matters as the age of the hospital, its total patients through the years, free service given, capacity, and so forth, should be woven into the story whether or not they appear in the fuller report. This may be done by sentences and clauses made a part of the telling of the work of the current year. The impressionistic style can be used here, such as theatrical critics use in their account of "first nights," giv-

ing a wealth of concrete material and, at the same time, having the atmosphere of the hospital, its purpose and its ministry of service, pervade every paragraph.

The Picture Folder

Many people prefer to receive information largely through pictures. This gives opportunity for service to the picture folder. The Bronx Hospital, New York City, has produced one or two effective picture folders. The first is "The Gateway to Health" a four-page folder, four by eight and one-half inches, printed in brown on an ivory paper. The front page bears the title at the upper left hand, the four words being one above the other. At the bottom, allowing a three quarter inch margin, is a two and three quarter by two and one-fourth inch half-tone of the hospital gate swung open, with a one-eighth of an inch from edge white line all the way round and crossed at corners. No line surrounds the half tone. Pages two and three contain eleven pictures so arranged that those at right, left and top bleed. In the center is the Bronx Hospital. On the left a scene in an operating room and on the right a group of nurses. The four pictures across the top are a nurse with her arms full of babies, a picture of the use of the fluoroscope, a convalescent scene and a baby being dressed. At the bottom a nurse is giving medicine, a doctor is examining a patient's throat, the kitchen is shown with the chefs at work and a look into the laundry is permitted. The only type used is for captions and the captions augment, rather than duplicate, the story which the pictures tell.

After studying these pictures a few minutes, one is ready and interested on turning to the fourth page to read, among the half dozen paragraphs there, the following:

"Recognizing the extreme need of additional hospital care for the sick and needy of the community, The Bronx Hospital opened its building in July, 1920, with a bed capacity of one hundred and a dispensary. And since its inception it has grown to such an extent that it is constantly forced to refuse admission to deserving patients, only because of lack of space.

"So great have been the demands on it that by the end of 1922 it had already given 79,028 hospital days to the sick, its dispensary gave 91,603 treatments, its pharmacy filled 58,695 prescriptions for the poor; its maternity ward brought into the world 1,610 sturdy youngsters without any casualty either to mother or child.

"The mortality rate of the hospital has been only two and one-half per cent despite the hundreds of difficult major operations performed and serious ailments treated. This is a record unsurpassed. More than fifty per cent of the beds of The Bronx Hospital are given over to ward cases."

One who receives this folder will not lay it down until both the pictures and text are followed to the end. And in a remarkable way the text throws light on the pictures, and the pictures put human flesh on the bare statistical facts which the text presents.

In another six-page folder three and three-quarters by eight and one-fourth inches, this same hospital shows the growth of its plant, pictorially. It also shows on the inside of the folder three beds. Under the largest, one reads:

"When the population of the Bronx was 400,000 there was one hospital bed for each 425 inhabitants."

Under the middle size bed appears:

"When it grew to 800,000, the hospital bed capacity in the Bronx decreased to one for every 680 inhabitants."

Under the third and smallest bed one learns:

"According to present available statistics, the hospital bed capacity of the Bronx is one bed for every 750 of its inhabitants."

These beds and captions, with the statement that "Health authorities declare that every community should for its own protection have at least one hospital bed for every two hundred of its population," start the reader to thinking of hospitals in a most concrete and personal manner.

The possibilities of the picture folder both in size, variety, and arrangement of the pictures and uses in distribution, are almost without limit.

The Leaflet Family

Unusual publicity service is rendered by four or eight-page self cover, three and three-quarters by six and one-fourth inch leaflets. They are inexpensive and give opportunity for exploiting each individual phase or department of the hospital's activities. A leaflet of eight pages gotten out by the Wesley Memorial Hospital, Chicago, Ill., illustrates this class of hospital literature. On the front cover, at the very top, appears the title "Before Nurse Says to You 'Good Morning'." Then comes the name of the author and below it the statement:

"From city and from country the cry is 'Send us a Nurse.' In the past year by legislation alone, positions were created for 50,000 public health nurses and only 9,000 were available. The path of an 'R. N.' is a royal road to be travelled only by girls of sound physique, strong purpose and with a passion for service."

The first inside page has a half tone of a nurse bandaging a young man's wrist, with the caption "Nurse Has to Attend to Many Interesting Emergency Cases." Then starts a composite story of the training and duties and opportunities for service that constitute the daily life of a nurse. It begins with the rising gong at five forty-five in the morning and follows the nurse through the day and night. And it is packed full of concrete information of what the hospital is doing, as the nurse comes in contact with instructors, doctors and surgeons, supervisors, patients and recreational leaders. It makes a strong appeal to young womanhood to enter nursing service. It also puts the work of the hospital before every reader in a new and delightful manner.

This same type of leaflet and style of treatment can be used for every part of a hospital's work. And it makes such fascinating and instructive reading that one begins to feel a part of the hospital itself. For example, "When the Operations Are Over" could well bring the surgeon's daily tasks before the public in a way that would be read with avidity. "Getting Jones Through Pneumonia" lends itself to the physician's daily

routine. "What the Ambulance Brought In" would furnish a title for a day's trips in bringing the injured and sick for treatment. "Being Born in a Hospital" gives the cue for the maternity work done. "Seeing Inside of Folks" would start a first class x-ray leaflet. "346 Miles of Sheets" introduces the story of linen supplies, etc., and the laundry work of the hospital. "They ate 2,100 Loaves of Bread Last Week" gives opportunity for a story of the food consumed. Or if desired, "125 Cows Work for the Hospital Every Day." There is one of the finest opportunities, in a series of such leaflets, to get the entire story set forth in interesting chapters, each of which is a unit in itself.

Talking Points

For those who like to get their facts boiled down a leaflet of "talking points" should be prepared. And people of this sort are very numerous. The best way to prepare "talking points" is to list up all the facts and figures involved in the work of the hospital, divide them into natural groups with a heading for each group and then boil them down. And then boil them down again. It is well to so arrange the points presented that each new section starts a new page. This gives a "snappier" look to the points and keeps one entire division of points before the eye at once.

The divisions under which the "talking points" are listed will vary with the individual hospital. A few suggestions are "A Little History," "Purpose and Work", "Departments and Treatments", "Costs and Maintenance", "Number of Patients" (giving totals, departments, free, part pay, and full pay, etc.), "How the Hospital is Supported", "The Social Department", "Preventive Work", "The Nurses' School", "How the Medical and Surgical Staff is Made Up", etc. Your own institution will furnish you the divisions you desire.

A sample page of the talking points might work out as follows:

1. By becoming a regular annual subscriber to the Free Bed Fund.
2. By the gift of $300 yearly to support a free bed.
3. By giving $5,000 to endow a bed in perpetuity.
4. By giving $20,000 for the endowment of a private room in perpetuity.
5. By giving any amount to the endowment fund, that your money may be doing good long after you are gone.
6. By remembering the (use name of your hospital) Hospital in your will.
7. By seeking to interest your friends in the work of (name of your hospital) Hospital.
8. By recommending ..... Hospital to persons requiring hospital care.
9. By using your influence to have societies of which you are a member support ..... Hospital regularly.
10. By sending donations of fresh eggs, table delicacies, such as jams, jellies, canned fruit, pickles, marmalades, etc., through the organizations in which you are interested.
11. By organizing Hospital Aid, Florence Nightingale, ... Hospital Workers, or Free Bed Fund Societies among your friends.
12. By visiting ..... Hospital and acquainting yourself with its work and needs. (Visiting hours are 2 to 4 p. m. every day.)

These twelve "talking points" will suggest the range and concreteness which should characterize each division. Careful study and hard work on this will result in a little booklet that will be invaluable, both for those representing the work and needs of the hospital to others, and for putting into the hands of individuals. It can be revised, brought up to date and freshened up from time to time, with a slightly different arrangement, different colored paper and a change of ink to give it a different appearance.

There is an increasing tendency among people making gifts to hospitals to desire that they be invested in something that will give permanent returns. This tendency demands the creation of folders setting forth the need of memorial buildings, rooms and beds. This type of literature should be written in an interesting, but dignified style, and should make very clear why such memorials are needed and give such details as will satisfy a prospective donor's judicial mind.

The same is true with reference to literature seeking for permanent endowment. Here the amount of endowment the hospital now has, how it is invested and what is accomplished with the interest, should be stated, together with reasons for asking for increased endowment, and what in definite work, additional endowment will make possible.

For annuity bond folders there is a wealth of printed material available as nearly every cause and institution in the land is persuading people to invest in this form of giving. A study of this literature will give all the suggestions needed, both as to form and content.

Using the Opportunity

There is practically no limit to the opportunities which booklet and leaflet publicity presents. Naturally the whole range of this phase of hospital publicity could not be discussed in detail in a single article. The whole matter of campaign-literature must be discussed later. But enough has been said to permit an alert hospital executive to catch a glimpse of a form of propaganda that he may use to advantage, and should use without fail.

Of course not all that has been suggested, or that will suggest itself to the reader with this as a point of departure, can be done at once. But a start can be made, and gradually a body of booklet and leaflet literature will be developed that will work day and night for the institution.

The whole matter of effective distribution must be discussed later also. But begin the preparation of one or two booklets and leaflets. Study the material and what you desire to do. And whatever is done, make it as good both in content and form as the printed matter now advertising things purely commercial.

AN INTRODUCTION TO THE HOSPITALS OF PORTO RICO*

By J. G. TOWNSEND, M.D., Surgeon, U. S. Public Health Service, Washington, D. C.

THE island of Porto Rico, acquired by the United States from Spain subsequent to the Spanish American War, is a part of the Western Antilles, lying between north latitudes sixteen and twenty in the south Atlantic Ocean 100 miles due east from Haiti and the Dominican Republic and about 500 miles south east direct from Key West.

Its natural beauty of tropical verdure, rolling hills and mountains, its beaches, and good roads, have made it universally known, as well as have its industries of growing and shipping tobacco, coffee, sugar, cocoanuts and citrous fruits.

Although it is only approximately 100 miles long (east and west) and thirty-six miles wide, with a square mileage of 3,600, it supports 1,250,000 people. The wage earners are engaged in the various trades and industries adaptable to the location.

Fight Tropical Diseases

Besides the usual diseases of man, the people of Porto Rico have to contend with unduly high prevalence of malaria and hookworm, although through the work of the International Health Board and the Insular Department of Sanitation these diseases are beginning to give way to modern preventive and curative methods. The United States Public Health Service has conducted a tuberculosis survey in collaboration with the local health department to assist in determining as nearly as possible the extent and scope of the disease as well as the factors most prominent in influencing its spread in the island.

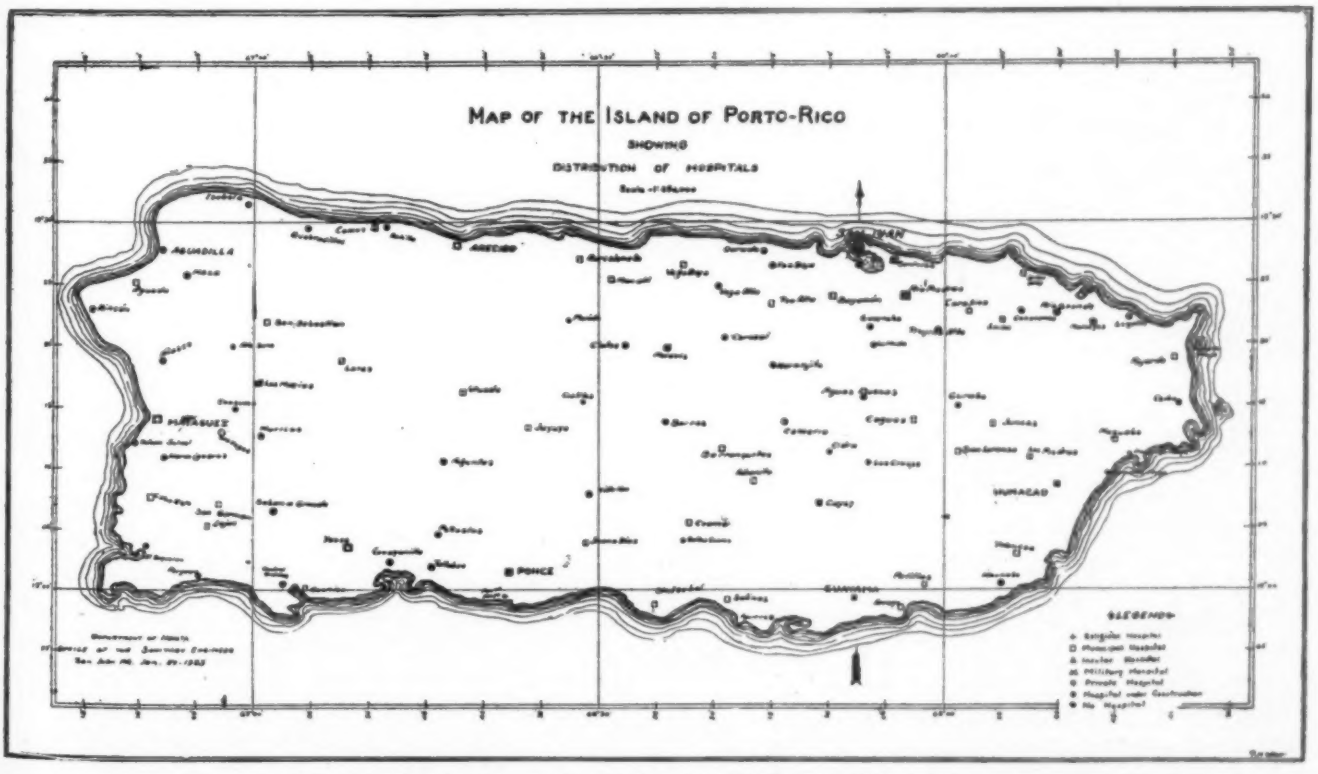
Burden upon Insular Physicians

It is obvious that the people of Porto Rico are dependent solely upon the insular medical profession for relief and accommodations provided in the various hospitals which are scattered uniformly throughout the island.

In general, these hospitals may be divided into five large groups.

(1) Those maintained and operated as municipal hospitals. (2) Those maintained and operated by the insular government. (3) Those maintained and operated by religious organizations. (4) Those maintained and operated by

*Published by permission of the Surgeon General, U. S. Public Health Service. This is the first of two articles on Porto Rico Hospitals which will appear in THE MODERN HOSPITAL. The second article will contain pictures of a number of hospitals in Porto Rico.



Map of the island of Porto Rico showing distribution of hospitals by type.

private agencies. (5) Those maintained and operated by the U. S. Army.

There are in Porto Rico seventy-six municipalities each containing a city or town which is the center of the municipal government, corresponding to counties and county seats in the United States. It is in these sub-capitals, or county seats, where one finds the municipal hospital.

Forty Municipal Hospitals

At present there are forty such hospitals, and new construction is now going on at Comeriio, Hormigueros, Maricao and Mayaguez. In San Juan, Caguas and Maunabo contemplated projects are also under way for new hospital construction.

The municipal hospitals in operation all maintain rather extensive charity clinics for the poor of the municipality in question, while municipal physicians are available for calls to the homes of the patients when their conditions do not permit their coming to the clinic. This method of procedure will be discussed in a subsequent article. In brief, the municipal hospitals of Porto Rico are mainly charitable institutions, though accommodations are also found for the pay patient.

Insular Hospitals

The hospitals maintained and operated by the insular government through the department of sanitation are as follows: —

(1) A tuberculosis sanatorium at Rio Piedras where approximately 150 patients are treated (not advanced cases).

(2) A tuberculosis sanatorium at Ponce where eighteen patients are treated.

(3) A leper colony on a little island in San Juan Bay, where approximately thirty-seven lepers are now hospitalized and being given regularly the chaulmoogra oil treatment when indicated.

(4) A hospital in San Juan of 513 beds for nervous and mental cases, in operation since 1844.

These hospitals are all charitable institutions though no clinics are operated in connection with them. The department of sanitation does, however, through its laboratory at San Juan, accomplish laboratory analyses and examinations for the municipal hospitals upon request.

Religious Hospitals

The hospitals maintained by religious orders are as follows:—

(1) The Presbyterian Hospital at San Juan,

(2) St. Luke's Hospital at Ponce, partly maintained by the Episcopal Church,

(3) The Ryder memorial Hospital at Humacao of the Congregational Church. At this hospital a new addition has just been completed which will accommodate about twenty more beds.

For purposes of convenience, and to prevent overlapping and duplication of work, the various religious denominations are confining their activities to certain districts, mapped out geographically, and do not attempt to expand their churches, chapels, and classes beyond the fields alloted. Not so with the hospitals, however. The hospitals at San Juan, Ponce and Humacao are open to all, when accommodations will permit, irrespective of residence, creed or color. A resident of San Juan may find hospitalization in the St. Luke's at Ponce, and conversely a Ponce resident may be taken in at the Presbyterian at San Juan. Large clinics are operated in connection with all three of these religious institutions.

Private sanitariums or clinics operated by a group of doctors in connection with their practices are not numerous. They are about eight in number.

Private Institutions

Under the category of private institutions may be mentioned a large hospital of 120 beds near San Juan operated by the *"Sociedad Española de Auxilio Hutuo y Beneficencia de Puerto Rico."* This institution is rather unique. It is supported by the society which is composed of some 2500 members, each paying three dollars monthly towards that end. The dues are paid during health and when sickness comes a member is entitled to treatment in a private room. It is in reality a system of health insurance on a small scale. Membership in the society is open to all irrespective of nationality. A general free clinic is not operated in connection with this hospital, but charity cases are admitted to the institution among the Spanish sailors, and all types of poor Spanish subjects.

U. S. Army Hospitals

The U. S. Army operates two hospitals for its beneficiaries—one at San Juan, and the other at Cayey where a large wireless station is in operation.

The accompanying outline map is prepared for ready reference to indicate the distribution of hospitals according to type. The cross indicates the religious hospitals. The triangle the insular hospitals, the square the municipal hospitals, the circle the private institutions, and the crossed sabers the military hospitals.

It is with books as it is with men; a very small number play a great part; the rest are confounded with the multitude.—Voltaire.

DIAGNOSTIC LABORATORIES OF THE SMALL HOSPITAL*

By KANO IKEDA, M.D., Pathologist, and Director of Laboratories, Minneapolis General Hospital, Minneapolis, Minn.

The increasing need for diagnostic laboratories confronts the small hospital. The demands of modern science make the laboratory an invaluable asset to diagnosis to the small as well as to the large hospital. But in the case of the latter, the laboratory brings with it attendant difficulties in the way of maintenance. In addition to the initial cost of equipment and installation, the small clinical laboratory requires at least two skilled technicians in order that the laboratory may operate efficiently. Thus financing of the laboratory becomes a problem which hospitals have sought to solve by several methods, only two of which, make a reasonable appeal for consideration.

THE ROLE of the diagnostic laboratories in a modern hospital is one of the most pertinent factors in determining the standard of that institution. It is a fair index both to the scientific qualification of the physician and to the professional care of the patient. It is considered as one of the bases for the recognition of a hospital by the American College of Surgeons. It has furnished a topic of animated discussion at every hospital conference held within the last five years.

Consequently, a large number of hospitals have elected to enjoy the service of properly equipped diagnostic laboratories by adopting the college's program either in part or as a whole.

The present paper does not intend to trespass upon the premises of the laboratories of so-called recognized hospitals. It is assumed that these hospitals, with few exceptions, are maintaining these laboratories on the highest possible plane according to their individual circumstances in order to consistently meet the standard requirements of the college.

Difficult to Maintain Laboratories

Smaller hospitals, on the other hand, with a possible exception of privately owned institutions or those affiliated with so-called clinics, find it most difficult to properly maintain these laboratories without imposing a heavy financial burden directly upon the already over-taxed management with results most unsatisfactory to the conscientious medical man and often disastrous to his patient.

Physicians who frequent these non-recognized hospitals may still cling to a well digested clinical history and physical examination for diagnosis and treatment, often irrespective of laboratory and roentgen findings, looking to the latter merely as an unnecessary financial burden to the patient of average circumstances. Then superintendents of these hospitals may still cherish an idea that these laboratories must be a profitable business in themselves in order to justify their continued existence. These conceptions are the most potent practical obstacle to a successful re-organization of these departments within the hospital.

Even men associated with so-called recognized hospitals, are occasionally found to be still harboring these ideas. A further complication is encountered in the existing practice of a certain number of the visiting physicians who conduct their own laboratory examinations upon their hospital patients and that of certain others who prefer to patronize outside laboratories for their cases.

Aid in Diagnosis and Treatment

The first and primary function of the hospital laboratories is to aid in correct diagnosis and to guide in proper treatment by furnishing to the attending physician certain negative or positive findings by various methods at their command in such specimens as are collected for necessary examinations. It is evident that these findings, individually and collectively, are not only the strongest collaborator but the most reliable pilot in clinical diagnosis; secondly, their proximity to the sick and helpless in the hospital makes it most ideal for the rendition of efficient and prompt service, by reducing the time element and other inconveniences to the very minimum.

Third, these laboratories must issue such reports in certain prescribed forms as are essential in completing the clinical record of the patient. The well kept clinical record is a valuable by-product of the practice of scientific medicine and may find a permanent place in medical literature when properly analyzed and assembled.

Fourth, the hospital is understood to be free from taint of commercialism and its laboratories

*Read before the Five States Hospital Convention, held at Minneapolis, Minn., May 17-19, 1923.

are accordingly operated on a humanitarian and scientific basis rather than as a commercial enterprise. This, in itself, should appeal to the average physician who is eager to render the best possible service to his patient at the least possible expense.

The hospital should avail itself of this opportunity and endeavor to respond to this expectation and demand to the fullest extent.

Furthermore, these diagnostic facilities shall eventually be brought up to the sphere of such practicability and usefulness as to encourage the physician to register his patient into the hospital for no other purpose than that of scientific diagnosis.

Qualities of a Successful Laboratory

Proper organization and successful operation of the diagnostic laboratories depends entirely upon the following cardinal considerations: First, technician; second, personnel; third, minimum service; fourth, equipment; fifth, finance; sixth, minimum required routine examinations; seventh, record.

First, comes the technician. Every hospital, no matter how small, should employ at least one full-time technician to take charge of its diagnostic laboratories. A hospital of over fifty beds with well-functioning laboratories will doubtless require one technician in each of the two major departments, namely, x-ray and the clinical laboratory. The technician alone determines the character of service rendered and invites the appreciation and support of the staff: upon her qualification to properly fill the position largely depends the success of this enterprise. Her essential qualities may be summarized as: skill and accuracy, conscientiousness and honesty, initiative and alertness, self-confidence and patience, tact and pleasing personality. By demonstrating these qualities in her daily practice the confidence of the physician is at once won which practically guarantees her own position as well as the future of these laboratories.

The technician in the clinical laboratory must be a master of every technic which is included in the list of the minimum required procedures (to be discussed later). These required procedures can be fully mastered by any intelligent high school graduate of mature age who is given a thorough practical course of training among most favorable conditions, such as afforded by a large general laboratory.

The x-ray technician too must have had a reasonable amount of training in a larger laboratory where a fairly large number of various roentgen examinations are daily conducted. It must be remembered that the more limited and inexpensive the equipment, the more trained the technician must originally be in order to obtain satisfactory results. In the average laboratory the quality of the films are equally as essential as their interpretation in order to retain professional favor. And, this depends, in a large measure, upon the technic of the technician.

Too Many Ill-Trained Technicians

Too many ill-trained technicians of very limited experience are being employed by superintendents and physicians throughout the country. It is for the best interest of reputable technicians as well as the medical profession in general that future technicians shall be required to properly register with a board or a central agency according to their preliminary education, technical training and experience and specification of subjects mastered, and shall present such a certificate or credential as the registering board issues to them when applying for a new position. Medical societies with the cooperation of hospital associations and other occupational agencies should maintain such a board for their own ultimate good. The average technician can be had at $100 or $150 a month with full maintenance.

Second, comes the personnel. Beside the technician, a hospital, regardless of its size, should endeavor to employ a pathologist at least on a part-time basis who acts as a consultant to the attending men, directs the work of the technician and makes microscopic diagnoses of surgical specimens and personally supervises certain important examinations.

A qualified roentgenologist who interprets roentgenograms whenever called upon should be retained in a consulting capacity.

One practical difficulty is the scarcity of these specialists outside the larger cities. In a large majority of cases a substitute means must be resorted to.

In any event, there must be a medical man within the call of the technician to consult with her in her daily problems and share with her some of the responsibilities of the diagnostic laboratories.

Minimum Service

The limitation and extent of service to be rendered by the clinical laboratory must be clearly defined by the hospital. In a small institution the following list of laboratory procedures may be accepted as minimum which can be performed by a technician of minimum qualifications.

1—Complete routine chemical and microscopical urinalysis.

2—Complete routine blood examination including recognition of usual morphologic changes in leucocytes and erythrocytes, and of malarial parasites.

3—Bleeding and coagulation time, platelet count, grouping, etc.

4—Routine cytologic and bacteriologic examination of spinal, thoracic, abdominal and other body fluids.

5—Routine, gross, microscopic and chemical examination of feces.

6—Routine, gross, microscopic and chemical examination of gastric and duodenal contents.

7—Routine bacteriologic smears and cultures for recognition of commoner pathogenic micro-organisms.

8—Routine, gross, microscopic and bacteriologic examination of sputum.

9—Frozen sections and staining of surgical specimens.

10—Chemical examination of blood for sugar, creatinin, CO_2 determination and of urine for quantitative albumin, sugar, chlorides, urea, etc.

11—Miscellaneous tests of simple character.

As already explained, these procedures can be mastered by any intelligent young woman of high school education, after a reasonable period of proper training and, for that reason, should constitute the minimum service accepted by any hospital.

In the roentgen department all the routine roentgenograms including those of head, mastoid, sinuses, spine, stereoscopic chest and possibly gastro-intestinal tract should be taken care of, no matter how limited the equipment. Roentgen therapy should ultimately be outside the domain of the diagnostic laboratories.

Equipment of the Laboratory

Fourth, these laboratories should be located in the choicest quarters of the hospital. The antiquated basement idea must be forever discarded. Efficiency of the workers is greatly influenced by the general atmosphere within and surrounding these laboratories.

The amount of the equipment necessary is determined by the extent and scope of the service to be rendered. The minimum required procedure such as just outlined demands the installation of the following equipment:

1.	Van Slyke CO_2 apparatus		$18.50
2.	Electric incubator		75.00
3.	Electric centrifuge		55.00
4.	Microscope		120.00
5.	Microscope lamp		3.75
6.	Freezing microtome		75.00
7.	Refrigerator		
8.	Analytical balance and weights		72.50
9.	Harvard trip scale and weights		19.00
10.	Hemoglobinometer, Dare's or Sahli		39.00
11.	Hemocytometers and extra counting chamber		98.00
12.	Colorimeter		18.00
13.	Duodenal tubes		5.00
14.	Gastric evacuator		5.00
15.	Hot air sterilizer		41.00
16.	Arnold sterilizer		14.40
17.	Chapman filter pump		2.35
18.	Bunsen burners, two		.64
19.	Tripods with three rings		.75
20.	Wire gauze, two		.34
21.	White filter paper assorted		.50
22.	Test tube baskets, two		1.00
23.	Dunning P.S.P. colorimeter		6.50
24.	Thermometers, two		3.00
25.	Wire test tube holders, two		.16
26.	Test tube racks, two		3.00
27.	Test tube brushes, a dozen		.75
28.	Burettes supports		2.25
29.	Luer hypodermic syringes, 2 cc capacity.		1.00
30.	Luer hypodermic syringes, 10 cc capacity.		2.40
31.	Assorted hypodermic needles		1.75
32.	Red blood diluting pipette, two		4.00
33.	White blood diluting pipette, two		4.00
34.	Automatic blood lancet.		2.00
35.	Microscope slide box		.10
36.	Mohn's pinchcocks, six.		.90
37.	Cover glasses, 1 ounce.		.90
38.	Microscopic slides; 1 gross		1.35
39.	Esback albuminometers, one		.52
40.	Doremus ureometer		1.62
41.	Urinometer		.80
42.	Urinometer jars		.20
43.	Dropping bottles, 1 doz. 2 ounce		3.00
44.	Reagent bottles, 2 oz., dozen		2.40
45.	Water bath with rings.	$	2.00
46.	Glass marking pencils.		.15
47.	Porcelain evaporating dishes, 60 mm, two		.44
48.	Porcelain casserole, 395, two		2.16
49.	Alcohol lamp, 4 ounce.		.53
50.	Syracuse water glasses, 1 dozen		1.00
51.	Chemical funnels, 2 oz.		.30
52.	Chemical funnels, 4 oz.		.34
53.	Chemical funnels, 16 oz.		.48
54.	Centrifuge tubes, plain 15 cc, 1 dozen		1.00
55.	Centrifuge tubes, graduated, 15 cc, 1 doz.		4.00
56.	Graduated cylinders, 25 cc capacity		.45
57.	Graduated cylinders, 50 cc capacity		.50
58.	Graduated cylinders, 100 cc capacity		.55
59.	Graduated cylinders, 500 cc capacity		1.20
60.	Cone graduate 1000 cc.		1.20
61.	Mohr burettes with stopcocks		2.20
62.	Petri dishes 100x15 mm, 6 dozen		16.80
63.	Culture tubes, 4x½ in.		2.84
64.	Test tubes, 6x¾, 1 gro.		2.84
65.	Mohr's pipettes, 1 cc. in 1/100, 1 dozen		3.60
66.	Mohr's pipettes, 1 cc. in 1/10, 1 dozen		3.60
67.	Volumetric pipettes, 1 cc, two		.36
68.	Volumetric pipettes, 5 cc, two		.36
69.	Volumetric pipettes, 25 cc, one		.32
70.	Beakers pyrex, 150 cc, two		.42
71.	Beakers pyrex, 250 cc, two		.50
72.	Beakers, pyrex, 400 cc, two		.60
			$767.97
73.	Volumetric flask, 250 cc, one		
74.	Volumetric flask, 500 cc, one		
75.	Glass tubing.		
76.	Rubber tubing.		
77.	Platinum wire.		
78.	Chemicals.		
79.	Stain and reagents.		
80.	Miscellaneous supplies		
	Estimated total		$825.00

The roentgen equipment may vary considerably. The most inexpensive set of equipment capable of rendering the minimum diagnostic service as outlined above may include: a 30 m.a. bedside unit with suitable accessories and wiring to enable not only roentgenographic work but also fluroscopic examinations. A technic can be developed so that practically any kind of diagnostic radiography can be satisfactorily accomplished by this machine provided a sufficient number of intensifying screens are on hand.

The following list may serve the purpose of supplying the very minimum equipment for a small hospital or a doctor's office:

1 Five inch, 30 m.a. transformer, bed-side unit	$ 885.00	
Transformer only		$ 585.00
1 Combination table without tube stand	980.00	
with tube stand		1,100.00
2 Coolidge tubes	250.00	250.00
1 High tension switch and wiring	75.00	75.00
2 set double intensifying screen, 14x17	130.00	130.00
2 set double intensifying screen, 11x14	85.00	85.00
4 set double intensifying screen, 8x10	100.00	100.00
Dark room equipment	100.00	100.00
	$2,605.00	$2,415.00

Vertical fluroscopic unit may be had for $500 where no combination table is in use.

Complete or partial control of the x-ray equipment in the hospital by the roentgenologist in attendance is to be avoided from the administrative point of view. However, the inducement of such an arrangement to a financially incapacitated hospital in providing a well-equipped and properly supervised laboratory is of sufficiently important moment to deserve the most serious consideration.

Financing the Laboratory

Fifth, how to properly finance these laboratories is perhaps the most perplexing practical question that confronts the hospital.

It is generally known that the majority of medical men object to the usual schedule of fees

adhered to by the hospital which is as a rule identical to that adopted by commercial laboratories and physicians' offices because of its prohibitive influence upon the physician who is compelled to forego many of the laboratory and roentgen examinations necessary for a definite diagnosis and for subsequent check on prognosis, etc., purely on account of the large expense such a practice entails.

This practice is economically unsound when one considers the amount of time and material required for most of these examinations and the qualification of the average technician who at her best is one comparable to a skilled laborer.

A leucocyte count done by a technician of proven ability requires less than fifteen minutes, the fee is $1.00. For a complete blood examination requiring about forty-five minutes to sixty minutes time, $5.00 is charged. Valuable as these findings may be in a given case, these charges are quite out of proportion to the actual work required and could easily be reduced to one half, especially when a fixed patronage is assured as in a re-organized hospital. The majority of routine procedures should come under the same category.

The superintendent, on the other hand, is ever being reminded of the fact that the investment as represented in these laboratories should be assured of a just return, not in a sense of commercial profit but simply as a guarantee of self-support and development. He insists on a sufficient gross income which guarantees a proper maintenance of these departments and if possible a reasonable return on its initial investment.

Therefore, frank and thorough discussion of this vital problem with the visiting physicians with the view of enlightening them as to the actual economic need of these laboratories and of arriving at a definite policy which adheres to a scheme of financing or a schedule of fees consistent with the humanitarian purpose of the hospital is most imperative.

In all events, a heroic and radical departure from the old order must come if a satisfactory solution of this problem affecting the very morale and efficiency of the service is to be expected.

To Abolish Individual Fees

The system of individual fees will eventually be eliminated at least by the hospital and a saner and less irritating method of charges will be adopted at least with reference to those examinations which can be accurately carried out by the routine technician.

Several methods have already been suggested and are in actual operation in some of the hospitals with more or less success. There are, however, only two at the present time which make a reasonable appeal for consideration.

First, a flat rate of three dollars is imposed as a laboratory fee to every non-surgical patient and of five dollars to those surgical cases whose tissue removed at operation is submitted to microscopic diagnosis which is understood to be obligatory.

All other examinations at the disposal of the institution are free to the hospital patient. This permits the privilege of repeats in indicated cases at the discretion of the attending physician without fear of extra financial burden which is more frequently the point of controversy across the cashier's counter at the very moment of discharge when the most lasting impression of the hospital is received by the patient.

A fifty-bed hospital should yield between $300 and $400 a month from these fees.

Second, an increase in rates of fifty cents a day per bed is in operation at a certain Illinois hospital with apparent success. A similar scheme with perhaps a less increase in rate appears to be a sound policy. Here, no charge is made through the laboratory except in cases of outside patronage. The patient would gladly pay twenty-five cents to fifty cents extra per day toward the general hospital care but may become unreasonably irritated over two or three dollars of extra laboratory charges.

This scheme should yield between $500 and $1,500 a month to a fifty-bed hospital which can be credited to the laboratories for their maintenance. A thoroughly modern laboratory under the directorship of a qualified pathologist is easily possible.

Advantages of System

The advantages of these methods of financing just described is two-fold: first, to eliminate the commercial aspect of the clinical laboratory by doing away with the much abused individual fee system and second to guarantee its proper maintenance, and employment of a strong personnel.

The wisdom of introducing such a radical policy should at first be submitted to the entire staff for study and approval.

High cost of x-ray examination is due not so much to the technical difficulty of roentgenography as to the difficulty in interpretation, to the expensiveness of initial equipment, and to the very limited number of available laboratories and of prospective patients. And yet, here again the average x-ray charges are altogether too exorbitant especially where no expert diagnostic opinion is given or necessary. At the present time, the average attending man, especially one who

specializes in a certain branch of medicine, prefers to diagnose or read the roentgenograms taken of his own cases. This necessarily relieves the hospital of providing an attending roentgenologist except in a consulting capacity. Where expert diagnosis of the roentgenologist is required, a regularly adopted professional fee may be charged.

Otherwise the patient should be given the benefit of a reduced rate. This should particularly apply to fracture cases where no outside opinion is usually necessary. Follow-up roentgenograms in these cases should be furnished at cost or at a considerably reduced rate.

Minimum Required Examination

Sixth, every hospital with the aid of its staff should adopt a list of the minimum required laboratory examinations which must be applied to every patient on admittance. This should include not only the routine urinalysis as in most of the standardized hospitals but also the hemoglobin estimate, and the leucocyte count and whenever indicated the differential and the erythrocyte count. All surgical specimens should be examined microscopically and diagnosed. The examination of a vaginal smear from every female infant or child in the children's ward is another routine which must not be overlooked.

Seventh, proper filing of records is absolutely essential in a modern laboratory. Alphabetical system alone will probably suffice for ordinary examinations, but a cross index in tissue and x-ray cases according to diagnosis and source or region is most desirable. In a smaller laboratory, the technician may find time to do it. Reports are not only properly filed in the laboratory but also promptly sent to the bed-side to be incorporated into the clinical chart. Report blanks are variously printed but should conform with the forms of other clinical sheets while the laboratory records may be best kept in cards to be indexed.

An attempt has been made in a general way to describe the minimum standard service of the diagnostic laboratories which is within the practical reach of very small hospitals.

In the final analysis, however, the success of such a service depends not so much upon the ability of the hospital to provide it but, to the greatest measure, upon the active cooperation and support of the physician whose ability to utilize and interpret laboratory findings to the maximum advantage is one great factor in modern medicine.

To raise the level of national health is one of the surest ways of raising the level of national happiness.—William E. H. Lecky.

PRESIDENT BACON REVIEWS TWENTY-FIVE YEARS OF ACHIEVEMENT

(*Continued from page 446*)

national prominence. This being true, we now pledge ourselves to do our utmost to the end that the hospital world will not be disappointed in its desire to acquire knowledge of us. * * *

This year has been full of activities, as you will see by the report of your trustees and your executive secretary. In these reports are the milestones that have rounded out our twenty-five years of service.

In starting out on a new era, the Association needs you, your ideas, your experience, your participation in all its activities, and you need the Association to develop you and your institution.

* * *

Thus I complete a brief history of our association, and what of the future? Who can prophesy? Can you predict the changes that will take place in your own institution in twenty-five years? No more can I prophesy the future of the American Hospital Association. However, I will submit four suggestions for your consideration, namely:

A section of state departments, a section on cancer control, a section on the care of the insane, and a section on chronic disease hospitals.

Dr. Goldwater in a letter August 23, 1923 says, "In view of the strategic position which the state authorities hold, their activities ought not to be ignored by the American Hospital Association."

I had hoped that the state associations would become so active that they would command attention of the state authorities to the extent that cooperation would be brought about for the mutual benefit of both. I see no future in this respect and am now satisfied that the parent association should take up the matter as soon as the trustees see fit to do so. The splendid cooperation we have had this year with the authorities in Washington encourages me in this belief.

Cancer is an institutional problem and one of which the superintendents should have more knowledge. Therefore, the association should have a section working together with the American Society for the Control of Cancer.

A section to develop higher standards in hospitals for the insane and to encourage departments of psychiatry in general hospitals to the end that insane patients will have the same careful hospital treatment that other patients receive.

The field of chronic disease hospitals is quite undeveloped. Therefore, the association should take up the question of a wide spread educational campaign to arouse a deeper interest in the hospitalization of chronic patients.

THE SUPERINTENDENT OF A STATE HOSPITAL*

TRUSTEES of a general hospital select its superintendent from eligible candidates. Their selection is not restricted, either by law or even by custom, to the medical profession. But whether they choose a medical man or a layman, they insist that, above all, he be a hospital man; that is, one who has training and experience that equip him to be the managing officer of the institution. The tendency probably in the general hospital world is to elect medical men to the superintendencies, though the requirement is just as necessary that the medical man combine with his medical training and experience those qualifications which are essential to the sound administration of business affairs.

Restriction Placed Upon Appointments

The trustees of a state hospital are seldom permitted to enjoy this freedom of selection, which is after all comparable with the freedom a well-managed industry enjoys of going into the market and employing the best skill it can afford.

In some states trustees of state hospitals enjoy more latitude in this matter than they do in others; but, with few exceptions, they are not able to exercise their best judgment. The day when they may employ as industry employs is yet a long way off.

Nearly every state provides by its laws that the superintendents of these institutions shall be members, in good standing, of the medical profession. Unfortunately these laws do not go further and require them to be also trained and experienced, state hospital men, which would include, of course, psychiatry as a part of their medical education and experience. Excepting in those few states in which superintendencies are promotional positions, either by civil service competitive examination or by a very definite custom, trustees who are appointees of the governor are often inclined to consult his political interest in filling them. The drift of the day, happily, is away from the political appointment, though the political notice is still often sufficient to handicap scientific progress and good service in this particular realm. If the ideal method of filling these positions is the method followed largely by successful general hospitals and by industry, its satisfactory application in the state hospital field would demand that more attention be given, the country over, to the make-up of their boards of trustees. It is necessary for a board of trustees of a state or general hospital or a board of directors of a business enterprise to be informed of the nature of the work to be done, the qualifications essential in those who are to be entrusted with doing it and many other phases of the subject.

Shifting Personnel

The personnel of the state hospital board has been changing too often and too suddenly. Continuous service of the right minds on these boards is very greatly to be desired. Among the encouraging signs is the disposition in some states not to interfere with these organizations when they are functioning harmoniously and efficiently. Not many are ready and willing to give the time or possess the attitude, the patience and the sympathy required to do this special task with an undivided devotion. When such individuals are found, they should be assured of tenure and sustained support.

The evolution of a reasonably satisfactory method of selecting a state hospital superintendent may be slow. What many consider the ideal method, that of the general hospital and industry, is still out of the question in some states. An even better method will be slowly adopted in a service where political aspects are prone to inject themselves and sometimes do so when and where least expected. There is no absolute insurance or protection against it. The civil service method has been tried. Where the law has been applied honestly it has succeeded in bringing into the service and in keeping there a high quality of men and women. These laws classify the employes of the state hospital, including employes from the lowest to the highest. The superintendency is a promotional position open to those of the rank next below. This system has worked well, notably in New York.

Merit System and Public Sentiment

But this merit system method will be almost worthless unless a public sentiment exists in the state strong enough and definite enough to protect this service from profane influences. Otherwise the law itself may be made ridiculous.

A few states, by custom, leave state hospital superintendents in office as long as they care to remain and also, by custom, fill vacancies from the next lower rank. The majority, however, cling to the old custom of picking where the picking is best for the picker.

*This is the eighth of a series of articles on state institutions for the mentally ill which is being prepared under the direction of a special committee of the editorial board of THE MODERN HOSPITAL in co-operation with the National Committee for Mental Hygiene, and Mr. A. L. Bowen, former superintendent of charities, department of public welfare of the State of Illinois.

Happily, this system is losing caste in the public mind. Its doom is near at hand. It is an insult to intelligence and an outrage upon community sense of what is humane. By contact with general hospitals whose numbers have been increasing so rapidly, the people learn what qualities are essential in a superintendent. Knowledge of general hospitals, situated in their midst, naturally has opened the way to better insight into the state hospital. Hence in this country we see forming a far better attitude toward these institutions. One demand that is growing in insistence is that they shall be directed and administered by the right kind of men. And when they are, we shall see a tremendous improvement in the care and restoration of the insane.

The state hospital requires in its superintendent very much more than the average general hospital requires of its head. This much is obvious to anyone who knows the two types of hospitals and is conscious of the tremendous complexities and problems that beset the one but are comparatively unknown to the other.

Diverse Qualities Needed

If experience and other qualifications are to be secured for state hospital superintendencies, the source of supply must be within the institution itself. It is there only that men may acquire practical experience and knowledge, not alone in the diseases which they treat but in the problems of administration and management, which embrace almost every conceivable line of business, occupation, employment and profession.

The ideal superintendent must embody liberal knowledge of all these. In addition, he must possess the most important qualification of all, a spirituality, distinctive and well defined, for the peculiar environment in which he serves. He must be *a* spirit in the place and *the* spirit of the place.

Store of Inspiration Required

To be successful in the management of a state hospital, its superintendent must have a store of inspiration far greater, we believe, than is required in any other profession. There is lacking in the state hospital that which makes other business and professions attractive and stimulating, that is, profit. A state hospital makes no money. It takes in little or no money. It is supported from an appropriation by the general assembly. This appropriation has been cut to the bone, often by those who have no idea what they are doing, and care less. Any showing of economy is made at the expense of physical upkeep or maintenance of service. There is some encouragement in good gardens and farms, in fine herds of dairy cows and in poultry and hogs, but the income even from these passes either directly into the state treasury or may be used on the place to reduce per capita. In either event, the assembly in allowing funds has taken into account the probable income from these sources.

Results Not Inspiriting

The professional results are not inspiriting. A large per cent of those who enter are hopeless and are destined to remain the rest of life. The encouragement of patients, coming in, receiving scientific treatment and rising restored, to leave is ever present in the general hospital. Its atmosphere is such as to inspire hope. The scientific instinct is served. The character of the patient population in a state hospital and the relatively small number of absolute recoveries combine to depress the most buoyant spirit.

The superintendent who makes the greatest success possesses the spirit that rises above all else and keeps him on edge. Descending through the various ranks, it promotes interest in work, maintains courage among employees, rallies to the policies and the service, the very best that is in men and women who accept positions in these institutions.

There are such men in the state hospital service. They seem to be an inexhaustible reservoir of courage, ideas, moral as well as physical vigor. The scientific attitude holds under the control of a wide expanding humanity with which their souls are filled. With them the problems of administration seem to be clay, worked at will into the forms that please them.

Type of Man Depends on Election Method

If this service of the state guarantees to those in it and offers to those it would have, the opportunity to aspire to the highest rank, it will gradually fill with this type of men. Where this opportunity has been vouchsafed, it has brought into the service those who have remained and eventually have reached the place where their training and experience fitted them for a duty of an almost divine inspiration. They become a credit to their profession and contributors to the public and social welfare, to say nothing of their vast comforting influence upon the lives and sufferings of the miserable and unfortunate. Any method of selecting state hospital superintendents that does not give this factor in personality the high rating it demands is destined to failure.

When you are betting on an absolutely sure thing, save out five cents for carfare home.

EARLY MEETINGS OF THE AMERICAN HOSPITAL ASSOCIATION*

By DEL T. SUTTON, Former Publisher and Editor of the National Hospital Record, Detroit, Mich.

WHILE information concerning the early meetings of the American Hospital Association may not be of over-powering value to the hospital world of today, it may stir up some rather pleasant memories among those who were connected with the field during the earlier days, and to those of later years and of the present it may present interesting sidelights regarding activities of the association in the past.

At the first meeting held in Cleveland, Ohio, the proceedings were confined to the work of organization and consequently no papers were presented.

Outline Problems of Today

At the second meeting held at Pittsburgh, Pa., there were three papers presented: "Some Responsibilities of a Superintendent," by Charles S. Howell, superintendent of the Western Pennsylvania Hospital; "The Relation Which Should Exist Between the Superintendent of the Hospital and the Superintendent of Nurses," by Miss M. Helena MacMillan, then superintendent of nurses at the Lakeside Hospital, Cleveland, Ohio, and "Three Years of Growth in the Hospital Field," by the writer of this article.

Mr. Howell, prior to his entry into the hospital field, was a newspaper man, a man of broad experience in matters pertaining to public affairs, and was a writer of strength and virility. Following a general discussion of the responsibilities of the hospital superintendent, Mr. Howell concluded by saying: "The final idea of superintendency is this: if it is not now, it is destined very soon to become a profession on as solid a basis as are those under present domination. Properly conceived, the accomplishment of the results demanded of administrative possibility must of necessity come from education, intelligence, tact, integrity of intention, as well as of character, and a knowledge of human and official relations. These are the attributes of minister, teacher, lawyer, physician, scientist: are they not as well those of the executive of an institution which is sought alike by the 'king and the beggar, the rich and the poor?' Therefore, the greatest of the responsibilities involved by the profession is to look to it that it be magnified, exalted and respected." That Mr. Howell's admonition in his closing sentence has been kept in mind and carried into effect by those who have administered the affairs of the American Hospital Association is amply shown by the personnel of the present membership of the association.

As I now recall it, Miss MacMillan's paper threw several bombshells into the ranks. At that time, there was a predominant feeling among hospital superintendents that the nursing feature in hospitals should be under the control of the hospital superintendent, and the position of Miss MacMillan, who was at that time one of the advanced thinkers in the nursing profession, that the control of the nursing department should be more under the authority of the superintendent of nurses aroused considerable feeling, but this was slight in comparison with the long drawn-out contest over the same matter which took place for several years following.

Early Statistics Preserved

In the paper on "Three Years of Growth in the Hospital Field," I presented figures obtained through exhaustive correspondence with hospital officials illustrating the growth of the hospital field during the three years prior to the year 1900. These figures showed that during the three years approximately 1,000 new hospitals had been erected and opened, this being an increase of about sixty-five per cent, based on the most authoritative figures obtainable at that time. The estimated cost of the plants for the 1,000 new hospitals was about $50,000,000, an average of about $50,000 each. During the same period about 900 existing hospitals were enlarged and improved at a cost of about $30,000,000. In the hospital field there were employed about 65,000 persons, not including those engaged in hospital construction and in the manufacture and handling of hospital furnishings and supplies. The average salary and wage was $1.15 per day, thus showing that the hospitals paid out about $27,000,000 a year for these items. Available statistics showed that over 1,600,000 patients were annually cared for at that time, the service requiring about 40,000 physicians as house and general staff members, and about the same number of nurses, both graduate and pupil. The estimated value of the hospital plants was $125,000,000. About $16,000,000 were annually ex-

*This third article completes the series on the early history of the American Hospital Association prepared by Del T. Sutton. The first and second articles appeared in the September and October issues, respectively, of The Modern Hospital.

pended for provisions, $4,500,000 for medical and surgical supplies, $4,250,000 for heating and lighting, $7,000,000 for furnishings, and about $175,000,000 for all other expenditures, making a grand total of $215,000,000. Approximately 112,000,000 dozens of eggs were required annually, 165,000,000 pounds of butter, 68,000,000 pounds of coffee, 8,000,000 pounds of tea, 332,000,000 gallons of milk, 285,000 barrels of flour, 550,000 barrels of sugar, 1,500,000,000 pounds of meat, 2,000,000 pounds of oatmeal, 26,000,000 pounds of lard, and about $750,000 worth of soap, not including that for the laundry.

The above figures were of necessity largely estimates based on the law of averages as shown by the actual returns received from the hospitals replying to the request for information. A comparison of the above figures with those covering the present time will present a striking illustration of the importance of the commercial value of the hospitals in the American business world.

At the New York meeting, in 1901, papers were presented by Dr. C. Irving Fisher, on "The Superintendent Himself," (a classic in American hospital literature); Capt. John Fehrenbatch of the Cincinnati Hospital, on "The Non-Resident Indigent Patient,"; Honorable Byron M. Child, of the New York State Board of Charities, on "The Relation of the State to the Hospital"; Dr. H. A. Fairbairn, of New York, on "The Management of Hospitals"; Del T. Sutton on "Figures and Thoughts Regarding Hospitals and the Care of Charity Patients," and Mr. Charles S. Howell on "Hospitals of the Future."

First Records and Reports

At the Philadelphia meeting, in 1902, the matter of hospital reports and records was given its first real presentation before the association, this being a paper by Mr. James R. Lathrop, then superintendent of the Roosevelt Hospital, New York, N. Y. At that time Mr. Lathrop was an authority on this subject and his paper was of much practical value from the fact that at that time this feature of the hospital administration was in a very chaotic condition. "The Dispensary Service" and "Hospital Construction" were other papers presented and discussed.

The fifth annual meeting of the association was held at Cincinnati. In his address of welcome at that meeting, the vice-mayor, among other things, said: "We want you to see and meet our people." Well, a good many of the Cincinnati people were seen and met, and hospital officials returned from the meeting feeling that they could honestly answer "Yes" to the query of the chap in the play, "The Prince of Pilsen", who asked "Haf You Efer Been in Cin-cin-nat-i?" Papers were presented on "Hospital Housekeeping", by Miss Josephine F. Royan, "Hospital Housekeeping", by Miss M. W. McKechnie; "Hospital Cleaning", by Miss Maud Banfield; "Notes on the Requirements of Modern Hospital Architecture," by the late Dr. Arthur B. Ancker; "Hospital Architecture", by Frank Miles Day; "Modern Hospital Architecture—the Pavilion Hospital", by Dr. Henry M. Hurd; "How to Reduce the Annual Deficit", by Mr. George P. Ludlam.

1903 Meeting Starts New Epoch

From several viewpoints, the Cincinnati meeting may be considered as marking a new epoch in the work of the American Hospital Association. The program was arranged by Captain Fehrenbatch, who from his past experiences as a mechanical engineer, coupled with his later work as a hospital superintendent, viewed the needs of the hospitals from a practical working standpoint and secured papers and provided for discussions to bring out information of actual daily working value to hospital superintendents. It may be of interest to note that at this meeting the matter of uniform hospital accounting received its first official recognition through the appointment of Dr. George H. M. Rowe, superintendent of the Boston City Hospital, and Mr. James R. Lathrop, superintendent of the Roosevelt Hospital, New York, N. Y., as a committee to take the matter in hand for development. The developments since produced under the guidance and support of the association could not but bring much pleasure and satisfaction to Dr. Rowe and Mr. Lathrop were they now living.

The Retrospect

In the three articles I have presented on the organization and early work of the American Hospital Association I have endeavored to bring out facts known to but a few of the present members of the association, believing that these facts will be of general interest. From a small beginning, organized perhaps not under the most favorable conditions, the American Hospital Association has grown to its present commanding strength and influence, and this can not but be most gratifying to those who during the earlier years were in any way instrumental in advancing the work of the association.

CELEBRATES ETHER DAY

As is customary Ether Day was celebrated at the Massachusetts General Hospital on October 16. Clinics and demonstrations were held in the lower, out-patient, and surgical amphitheatres.

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GOALS TO ACHIEVE

IN VIEW of the twenty-fifth anniversary of the American Hospital Association, its retiring president, Mr. Asa S. Bacon, did well to devote his presidential address to a historical resume of the activities and achievements of the association during the past quarter of a century. This address, and the three historical articles by Del T. Sutton which began in our September issue, give a fairly detailed and comprehensive idea of the association's achievements, achievements of which its members and well-wishers may rightly be proud. These documents should be read and pondered by all members of the association, not only because of the interesting information they convey, but also for their stimulus to a broader and more intensive effort in building up the association.

Doubtless with this latter thought in mind, Mr. Bacon was not content merely to look into the past, but turned a prophetic eye to the future and urged the association to devise ways and means for enabling hospitals to cooperate more closely with our federal government and its various subdivisions; to place itself at the side of the American Association for the Control of Cancer in its fight to conquer this ravaging disease; to take a deeper and more intelligent interest in improving the care and treatment of the mentally ill in our state institutions and to further the provision of greater and better facilities for the care and treatment of the chronically ill.

These are objectives worthy of the metal of an association that has passed its twenty-fifth birthday. It remains for the members of the association to see that Mr. Bacon's prophecies become actualities.

SELECTING THE STATE HOSPITAL SUPERINTENDENT

NEARLY every state restricts by law the selection of superintendents of its state hospitals to medical men. No such provision affects the administration of general hospitals. State hospitals being features of the state, state owned, operated and maintained, may, however, be subjected to this limitation.

In this issue of THE MODERN HOSPITAL, the qualifications and the methods of selecting superintendents of state hospitals are discussed.

No argument is required in support of its principal contention that the political fortunes of the appointing power and the political strength of applicants for these positions should not dictate selections. It is most unfortunate that they do in many places. A humane nation should be

ashamed of a political system that preys upon the miseries and woes, sicknesses and distress of misfortune to gratify its selfishness and ambitions.

The surest and most satisfactory method of excluding political considerations in the filling of these positions is the education of the public to appreciate the hideousness and unrighteousness of it all. Until public sentiment is right, civil service laws or other legal devices to separate these superintendencies and politics will be indifferently successful.

When these institutions are removed from such insidious and corrupting influences, the question remains; what is the best way of choosing superintendents, and should they be restricted to the medical profession?

General hospitals do not appoint inexperienced men as superintendents. Whether a medical man or a layman is chosen, he must have had training and experience in business, organization and administration. Some very excellent results have been obtained by lay superintendents who are good business men, builders, organizers, coordinators and creators of morale.

The administration of a state hospital, nearly always very much larger and very much more complex than the average general hospital, demands business skill, executive capacity and morale building. The superintendent of such an institution is seldom able to give time and attention to its medical work and problems but delegates them to a chief of staff who should be an up-to-date man of medicine, devoting all his time and attention to the scientific side of the institution. Whether a medical man or layman is chosen as superintendent of a state hospital, the really important factor to look for is that peculiar spirit which an executive of a state hospital must possess in order to meet and overcome the depressions that are incident to it but are not found in other types of hospitals. An unusual degree of optimism, spiritual buoyancy, a keen sense of the humanities and a penetrating insight into human nature, both that which is normal and that which is abnormal and subnormal, are essential for a successful administrator. With these qualifications, of course, must go administrative ability, personality, training and experience in the task he is to attack; and vision, imagination, breadth of view, and liberality in all things. It is inconceivable that so great and so complex an enterprise as a state hospital of from 1,500 to 4,000 or 5,000 patients, 450 to 650 employees, 1,000 to 3,000 acres of land, should be entrusted to inexperienced or untried men or left to the fortunes and chance of political expediency.

PHYSIOTHERAPY TO THE FORE

A DEPARTMENT of physiotherapy may not be needed by every hospital, but every hospital needs physiotherapy and a physiotherapist." Thus did Dr. John Harvey Kellogg introduce one of the most illuminating and significant papers read at the twenty-fifth conference of the American Hospital Association, which closes just as we go to press.

Why should every hospital employ physiotherapy in its ministrations to the sick? Because, as the author of this paper points out, "the marvelous light thrown upon life processes, normal and pathological, by the revelations of physiology, bacteriology and physiological chemistry and the exposures of the fallacies of old therapeutic notions and the inertness or inadequacy of the great majority of drugs made by experimental pharmacology and clinical observation checked up by modern instruments of precision, have so completely transformed the practice of medicine that the war of the "pathies" ceased years ago for lack of anything of interest to war about. Everybody knows, nowadays, that sick people are not cured by either big pills or little pills, but by the *vis medicatrix naturae*. * * * "We have a very few specific drugs which cure by destroying parasites of some sort; but with very few exceptions, the agents which are really potent in combating disease are those which modify the blood or the blood supply, and these agents are almost wholly those which belong to the domain of physiotherapy which includes all therapeutic measures other than drugs and physic influences."

It is most encouraging to have Dr. Kellogg point out that the question of expense need not deter hospitals from the application of physiotherapy in its various forms, since very little expensive or special apparatus is required in most instances for the effective application of these forms of therapy.

And yet much as hospitals might wish to use physiotherapy on a large scale, they will not be able to do so until the teaching of physiotherapy is put on more efficient basis in our medical schools. The curricula of these schools must be modified to make greater provision for the teaching of physiotherapy in all its branches, for it is now recognized by most progressive physicians as among the most fundamental curative agencies.

While, as Dr. Kellogg points out, it is not necessary for every hospital to have a department of physiotherapy, there are, nevertheless, not a few hospitals large enough and financially able to

have physiotherapy departments that do not have them. Perhaps this is because in most instances they do not yet realize the place which physiotherapy has won for itself as a therapeutic agent. These hospitals have elaborate and finely equipped operating suites; they have well-appointed, though perhaps less elaborately equipped, pharmacies; but there is a woeful lack of facilities for the application of hydrotherapy, electrotherapy phototherapy and mechanotherapy.

Clearly the present is witnessing a sharp shifting of emphasis from pill therapy to physiotherapy; and it is meet that hospitals, if they are to be regarded as progressive, place increasing emphasis on physiotherapy, providing such facilities as can be used to advantage and doing what they can to see that an adequate personnel is trained to make a practical application of its principles.

WILL NEW YORK VOTE YES?

SOMETHING over a year ago the state of New Jersey attempted to raise $16,000,000 by a bond issue to rehabilitate and enlarge its penal, correctional and charitable institutions, and to build six new ones. An extensive educational campaign was conducted; friends of the unfortunate appealed to the voters for support. The bond issue was safe-guarded so that no additions could be made to taxes on its account. The campaign did much to enlighten the citizens of New Jersey as to its state institutions and their inadequacy. Yet, withal, the issue was defeated.

Stung into action by the death of twenty-two patients and three attendants in the fire which destroyed a portion of one of the buildings of the Manhattan State Hospital for the Insane on Ward's Island, New York City, the State of New York is asking its citizens at the coming election to be held on November 6, to vote on a proposed $50,000,000 bond issue, in order to enable the state to tear down the oldest and worst of its institutional buildings, many of them from forty to seventy years old, and to replace them with modern fire-resisting buildings, as well as to provide additional buildings, especially for the care and treatment of the mentally ill. New York state hospitals built to house 31,000 patients at the utmost have 38,000 patients crowded into them.

For twenty years the small annual doles by the state legislatures have been as but drops of water in a bucket, until the state is now faced with the necessity of filling the bucket with one fell swoop to the tune of $50,000,000.

Faced with such a situation it is inconceivable that, once thoroughly aroused to the intolerable situation which exists in their institutions, the citizens of New York State will not vote an emphatic "Yes."

DIGEST OF HOSPITAL LAWS

HOSPITAL superintendents and trustees can ill afford not to give the most careful study to a digest of hospital laws and decisions, with interpretations, which appears in the fourth edition of THE MODERN HOSPITAL YEARBOOK which will shortly be off the press.

This digest of laws and decisions has been prepared by John A. Lapp, L.L.D., director of the division of social action of the National Catholic Welfare Council, who, because of his research work on hospital law, is unquestionably the leading authority on this subject in this country.

To this digest is appended a survey of legislation affecting hospitals. This has been prepared by Miss Dorothy Ketcham, director of the social service department of the University of Michigan. Miss Ketcham is well qualified to make this digest because of the research work which she did in the legal aspects of public health and hospitals for the Ohio and Illinois health and old age insurance commissions, and her research in the medico-legal aspects of the workmen's compensation laws.

In his discussion of this broad subject, Mr. Lapp dwells upon the sources of the laws pertaining to hospitals, the interpretation of the laws by the courts, the exemption and non-exemption of hospitals from liability on contracts and for torts, what makes a hospital a charitable institution, and other equally important questions.

Following Mr. Lapp's discussion, Miss Ketcham cites a large number of cases which have come up in the courts relating to such diverse subjects as articles of incorporation, autopsies, disposal of dead bodies, care and treatment of patients, powers granted under the charter, contracts, damages, charitable purposes, restraint of inmates, hospital records as evidence, injury to employees, licensing of hospitals, appointment of officers and trustees, rules and regulations, exemptions from taxation trusteeships, wills, bequests.

No more accurate, comprehensive and authoritative article on this subject has ever been published. Hospital superintendents, generally, will wish to have the yearbook in which this article appears at arm's length for ready reference. It throws light on many perplexing hospital legal questions.

AMERICAN HOSPITAL ASSOCIATION HOLDS SILVER JUBILEE CONFERENCE

DELEGATES from all parts of the country and the Canadian provinces gathered at the Auditorium, Milwaukee, Wis., Monday, October 29, for the twenty-fifth annual conference of the American Hospital Association. The first general session was impressively opened Monday afternoon at 2:30 by the playing of the national anthems of the United States and Canada. President Asa S. Bacon presided and during the session members of the board of trustees were seated on the platform in Plankinton hall where the general sessions were held.

Invocation was by the Rev. Maurice F. Griffin, Youngstown, Ohio. The address of welcome was given by Dr. George Ruhland, commissioner of health, Milwaukee, Wis., who, in the absence of Hon. Daniel W. Hoan, mayor, extended a welcome to the delegates on behalf of the city of Milwaukee, and pointed out the benefits which this conference would bring to the city in the way of helping to solve its hospital problems. Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill., responded in a happy vein.

Dr. Mariano Tolentino, representative of the hospitals of the Philippine Islands and guest of the association, was asked by the chairman to make a few remarks concerning hospitals in the Philippines. He briefly summarized the situation, saying that out of eighty hospitals only twenty-five were operated by the government, sixteen by missions and four by associations, and that there is great opportunity for the American Hospital Association to cooperate in the greater development of hospitals in the Philippines.

Representative of Exhibitors Speaks

Capt. Arthur W. Dunbar, Bureau of Medicine and Surgery, U. S. Navy, made a few brief remarks concerning the condition of the hospitals in the U. S. Navy, saying that there are at present twenty-three hospitals containing from fifty to one thousand beds. This was followed by a brief talk by Mr. Roy Watson, chairman of the exhibitors committee, who pointed out the significant factors of this year's exposition, calling attention to its non-commercial aspects and to the greater development which it represents over all past expositions.

This was followed by the presidential address of Mr. Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill. President Bacon reviewed the achievements of the twenty-five years of the association, showing its growth and development, and outlined a few specific policies which he hoped to see accomplished by the organization within the next few years. An abstract of Mr. Bacon's address will be found on page 443 of this issue.

The remainder of the afternoon program was given over to reports of the various committees. The report of the board of trustees was read by Mr. Daniel D. Test, superintendent, Pennsylvania Hospital, Philadelphia, Pa., who outlined the work the association had accomplished during the past year. The full report will be found on page 503 of this issue.

The report of the treasurer was read by Dr. M. T. MacEachern, associate director of the American College of Surgeons, hospital activities, instead of by the treasurer, Dr. Robert J. Wilson, director of hospitals, health department, New York, N. Y. The report showed that the balance on hand on August 31, 1923, was $754.41. The disbursements and receipts of the year ending August 31, 1923, are given in detail in the report which was distributed at the convention in printed form.

The report of the executive secretary was read in full by Dr. A. R. Warner, executive secretary of the association, Chicago, Ill., Dr. Warner outlined the work accomplished by the association during the past year and

The big triumvirate of the convention. Left, President Asa S. Bacon; center, Dr. Malcolm T. MacEachern, who wields the association's new gavel this year; right, Mr. E. S. Gilmore, president-elect, and "crowning glory" of the silver jubilee convention.

made a plea for increased membership not only among the hospitals of this country and Canada but among other American hospitals. The full report will be found on page 503.

The report of the membership committee was given by the Rev. H. L. Fritschel, superintendent, Milwaukee Hospital, Milwaukee, Wis., who showed an increase of sixteen per cent institutional active members, seventeen per cent institutional associate members, eleven per cent personal active members and eleven per cent personal associate members during the past year. The total number of personal members of all classes for the year ending September, 1923, was 1,705, or an increase of 162 members.

An announcement was made by Chairman A. C. Bachmeyer, M.D., superintendent, Cincinnati General Hospital, Cincinnati, Ohio, that the report of the committee on forms would not be read, as it appears in printed form and that it would be referred to the administration section, Wednesday afternoon, for discussion.

The report of the committee on relations between hospitals, states and cities was read by Dr. A. R. Warner, in the absence of Mr. John E. Ransom, superintendent, Michael Reese Dispensary, Chicago. The report stated that very little information had been given by the various states and cities and that this had retarded the progress of the work of the committee. The report, however, was referred to the administration section, Thursday morning, for discussion.

The second report of the committee on floors was read by Mr. Frank E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio. The report stated that very little new material had been added to the preceding report, but that the committee was working on further development of what had been accomplished as indicated in the last report. The report was refered for discussion to the construction section, Tuesday afternoon.

Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich., who read a paper on "The Responsibility of Hospitals in Minor Operations."

The report of the exposition committee on buildings, construction, equipment and maintenance was not read because of the absence of Chairman S. S. Goldwater, M.D., director, Mount Sinai Hospital, New York, N. Y. Announcement was made that the written report would be submitted to the construction section, Tuesday afternoon, for further discussion.

The Rev. H. L. Fritschel, the busy chairman of the committee on arrangements.

In the closing announcements of the afternoon session, President Bacon read letters of greetings to the association and regrets from the following persons who were unable to attend the conference: President Calvin Coolidge; Former Vice-President, Thomas R. Marshall; Arthur Stanley, president of the British Hospital Association; Sir Napier Burnett, M.D., K.B.E.; Capt. D. J. Mackintosh of the Western Infirmary, Glasgow, Scotland; The Honorable F. Courtney Buchanan, secretary, The Cancer Hospital, London, Eng.; The Honorable H. E. Kater, president, Royal Prince Alfred Hospital, Sydney, N. S. W.; Dr. T. Torralby, Hospital Nacional, Havana, Cuba; Ex-Governor Frank O. Lowden, of Illinois; Governor Blaine of Wisconsin; Dr. W. J. Mayo, Mayo Foundation, Rochester, Minn., Surgeon General, Hugh S. Cumming, U. S. Public Health Service, and William J. Bryan, Miami, Florida, and the following past presidents: C. S. Howell, 1901; Dr. Renwick R. Ross, 1907; Dr. S. S. Goldwater, 1908; Dr. Frederick A. Washburn, 1913; Dr. Robert J. Wilson, 1917; and Del. T. Sutton, honorary charter member, 1899.

Conference Considers Standardization

The hospital standardization session Monday evening was opened by Dr. Malcolm T. MacEachern, associate director of the American College of Surgeons, hospital activities, Chicago, Ill., who introduced the first speaker and chairman of the evening, Dr. Albert J. Ochsner, president, American College of Surgeons, Chicago, Ill., In introducing the speaker, Dr. MacEachern recalled that at the seventh meeting of the association when only seventy-seven members were present at the conference, Dr. Ochsner had talked on hospital construction work. In his address, Dr. Ochsner impressed his audience with the great humanitarian interest which should be the underlying motive and the dominating influence in all hospital activities. He believes that the standardization work of the college should be concerned with trying to help each hospital to improve upon what it already has rather than to discourage it by destructive criticism. He emphasized, particularly, that the minimum standard did not aim at unreasonable

Dr. Henry Hedden, superintendent of the Methodist Hospital, Memphis, Tenn. He has the report of clinical and scientific equipment committee in his hand.

demands but that, even if some of its demands did seem unreasonable, their ultimate aim was the creating of better hospitals.

"The Hospital Program of the American College of Surgeons" was the subject of the address by Dr. Franklin H. Martin, director general of the college. Dr. Martin traced the development of the movement which was begun primarily as a means for the college to select its fellows till now when it has grown so broad in scope that it affects every hospital on this continent and every nurse and superintendent has been drawn into the vortex of the movement. Dr. Martin drew attention to the public interest which is being evidenced in the better hospitals movement, saying that standardization had done much in the way of removing the veil of mysticism which has obscured the truth of the science of medicine from the common people. It has shown the public, too, he said, that physicians can really work together for hospital development as well as they can cooperate with the scalpel.

Advocates Lay Medical Magazine

Dr. Martin confessed that in the past the medical profession has been too dignified but that it is gradually letting loose of some of its reserve and gaining the confidence of the common people by making public the truths of scientific medical knowledge. "People *are* interested in scientific medicine," said Dr. Martin, and he made a strong plea for the further encouragement of lay interest by advocating an international lay medical magazine which would be most carefully edited and its matter presented in a way which would appeal to the average lay person. He also urged hospital officials to do all they could to encourage the youth in the profession who are striving toward great accomplishment.

Justice—the Keynote of Standardization

This address was followed by "Fundamental Principles Underlying the Hospital Standardization Movement" presented by the Rev. C. B. Moulinier, S.J., president, Catholic Hospital Association, Milwaukee, Wis. "Hospitals are the post-graduate schools of medicine," said Father Moulinier, and he emphasized how the standardization movement is enabling hospitals to attain the ideal of being great teaching centers. He traced the development of the standardization work during the past seven years with which he has been intimately connected with the movement and forcibly brought out the underlying principle of justice upon which the movement rests; justice, first of all to the patient; justice to the hospital, justice to the nurse, and justice to the medical profession. The future success of the movement depends upon justice, he reiterated.

He strongly urged that the hospital and medical mind cooperate in determining what were necessities and what luxuries. He also warned against the extra-laboratory charges saying: "Put the extra charges on the luxurious room and on the extra comforts to the patients who can afford them." He stressed the new idea that everything in the hospital that makes for more scientific care is owed the patient and that nothing is too expensive if it has proven its worth in curing the patient.

Leadership Lacking, Says Dr. MacEachern

Dr. Malcolm T. MacEachern, associate director of the college, hospital activities, explained the working principles of hospital standardization. The three vital principles of the movement as outlined by Dr. MacEachern, were: Desire of hospital groups for this work, cooperation, and leadership. In pointing out the problems of standardization Dr. MacEachern enumerated some of the difficulties which are preventing many of the hospitals from meeting the minimum standard by giving a few statistics from the hospital survey. He said that fifty-seven per cent could not meet the requirement because of their deficient organization, ninety-seven per cent because of the inadequate records, seventy-three per cent because of failure to take action against fee-splitting, fifty-two per cent on account of their inadequate laboratories and poor records, and fifty-five per cent on account of their lack of x-ray facilities.

He said that lack of leadership was shown particularly in the poorly organized staff conferences and in the lack of cooperation of the medical men who have factional differences to overcome. In his suggestions as to the

Mr. A. G. Fegert, who kept the public informed through the newspapers of what was happening at the conference.

bettering of case records he advised the keeping of a record clerk or librarian and a place in the ward to expose the record. He urged also that nurses should be trained to make accurate observations and record them fully and comprehensively. He recommended that the laboratory technicians should be under the supervision of a medical man, if possible. He left the impression with his audience that the college did not want to rob the hospital of its individuality but rather wished to act as a service organization for stimulating the best type of hospital work.

The Minimum Standard Applied

The concluding speaker of the hospital standardization section, Monday evening, was Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, who talked on "Experiences of A Hospital Superintendent Before and After Standardization." Mr. Jolly told in an interesting and humorous way of his own experiences in connection with the standardization of his hospital, showing the changes and improvements in the institution which have come as a result of standardization.

"No plan has ever been evolved," said Mr. Jolly, "which has meant so much to the public (whether they know it or not) and to those who operate a hospital. It has been a wonderful instrumentality in the hands of superintendents for bringing about the cooperation that is needed to improve hospitals, and the whole nation is under a lasting debt of gratitude to Dr. Martin and the college for their contribution."

In enumerating the benefits which his hospital has derived from standardization, Mr. Jolly said: "Staff meetings which were once little better than social clubs have become scientific clearing houses for the benefit of the patients and the doctors. It has brought many to realize that there must be no stars but team work, and that each must have the benefit of the judgment of all the others."

Mr. Guy J. Clark, chairman of the committee on canned fruits and vegetables, and Mr. H. J. Southmayd. They appear to be enjoying the convention.

Speaking of the effect of standardization upon hospital records, Mr. Jolly said that standardization has taught that the man who will not keep good records must be removed for the benefit of the hospital, but primarily for the benefit of the patient. He drew particular attention to change which standardization has made upon boards of the trustees who are learning that they are not simply a finance committee but are actually responsible for everything that goes on in the hospital. "They have learned also," Mr. Jolly continued, "that in the past perhaps there have been unnecessary operations and, being for the most part conscientious business men, they want to know why and how to stop it."

Mr. Jolly concluded by expressing the appreciation of standardized hospitals of the spirit which that movement has injected into the institution and the greater cooperation it has promoted among employees.

Following the address of Mr. Jolly, Major Hedding, of the National Home for Disabled Volunteer Soldiers, Milwaukee, Wis., briefly told of the work the government is doing in helping the tuberculous patients of that institution. He said that in the last six months which were the first months of the institution, 500 patients had been handled and that only 272 were now in the institution. He predicted that in the next six months over 600 patients would be treated, because the men really want that treatment.

As leader of the discussion which followed, Mr. E. S. Gilmore, superintendent of the Wesley Memorial Hospital, Chicago, Ill., made a brief retrospect of the evening's program and drew attention to the invaluable work of the college in raising hospital ideals, and said that standardization was just a means to an end. He expressed the hope that in the future the college might institute legislation by which no man would be permitted to operate for compensation until he had spent a reasonable amount of time under an expert surgeon.

Dr. C. S. Woods, superintendent, St. Luke's Hospital, Cleveland, Ohio, made a few brief remarks in which he proclaimed his sympathy with the small hospital of from twenty-five to fifty beds and expressed the hope that larger hospitals would take an interest in the smaller ones. He advocated that attending staffs of hospitals choose certain research topics at their meetings and hold conference on those subjects as revealed in the study of their records.

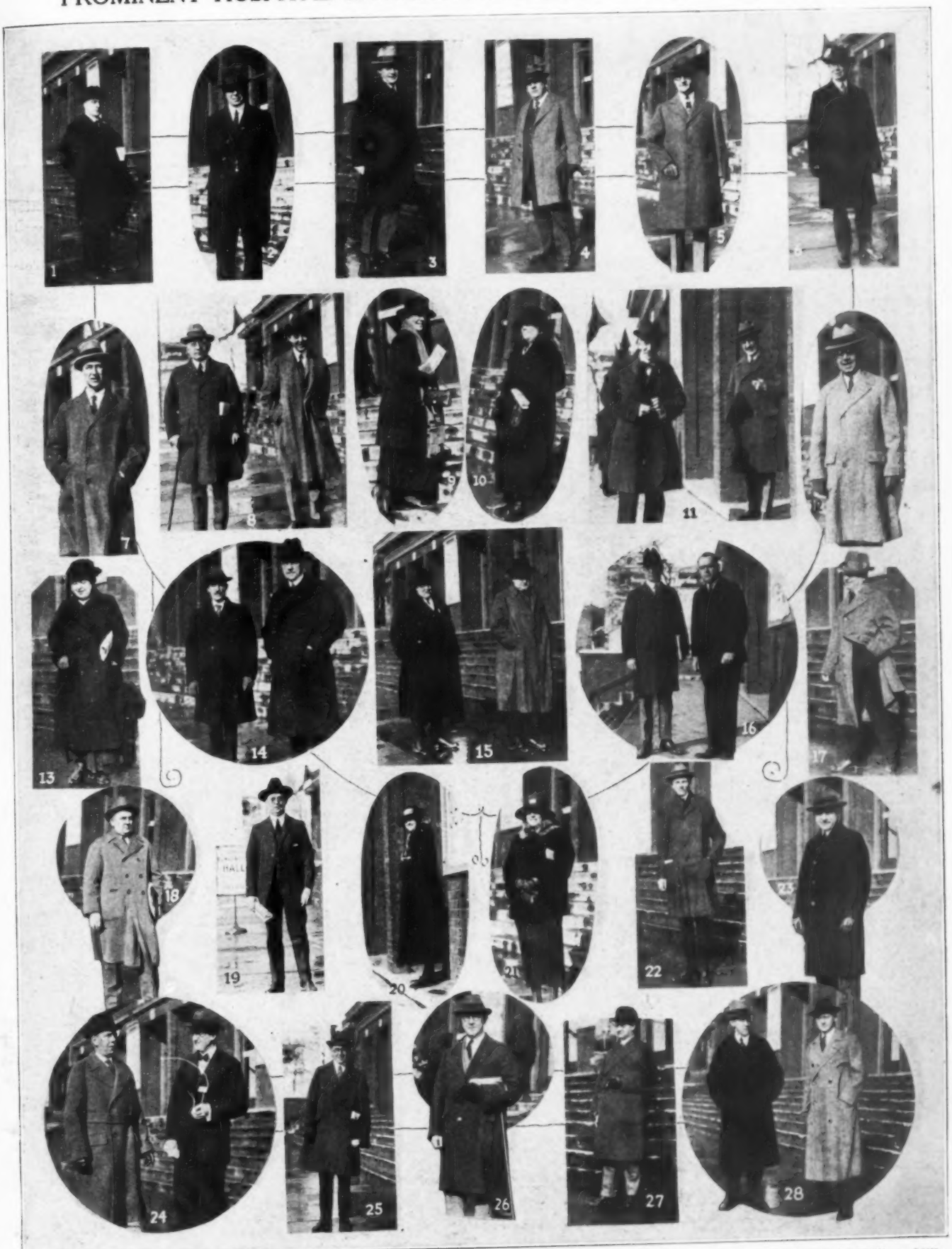
Following these discussions, Dr. F. Miller, Masonic Hospital, El Paso, and A. C. Scott, of the Scott and Whit Hospital, Temple, Texas, were asked to make a few brief remarks on the effect of standardization upon their hospitals which are held to be models of cooperation. The session was closed by a few words of appreciation from President Asa S. Bacon.

Exhibits Canned Fruit and Vegetables

The Tuesday morning general session was largely taken up with reports of the chairmen of various committees. Mr. Guy J. Clark, Cleveland Hospital Council, Cleveland, Ohio, chairman, committee on canned fruits and vegetables, announced that the committee would present its report graphically in the exhibit. He said that the exhibit contained fruits and vegetables from four of the large canning sections of the country which have adopted standard specifications for the packing of fruits by members of their association. The committee believed that this exhibit would best give hospital people a practical knowledge which is needed in an intelligent purchasing of these supplies.

Dr. Nathaniel W. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., read the report of the intern committee. The report showed an appalling lack of hospital internships, for out of 3,000 hospitals in this

PROMINENT HOSPITAL EXECUTIVES SNAPPED AT THE CONFERENCE



(1) Dr. E. R. Crew; (2) Dr. A. O. Funkelsrud; (3) Dr. W. P. Morrill; (4) Dr. W. P. Caldwell; (5) Frank E. Brooke; (6) William Mills; (7) Dr. George F. Stephens; (8) Dr. Walter H. Conley (left) Dr. George T. O'Hanlon; (9) Miss Charlotte J. Garrison; (10) Miss Margaret Rogers; (11) Richard P. Borden and Charles Lee; (12) Dr. D. H. Fuller; (13 Miss J. M. Geister; (14) Dr. Thomas Howell (right), Dr. Henry A. Jones (left); (15) Paul H. Fesler and Dr. R. E. Castelaw; (16) J. J. Weber and John E. Ransom; (17) Dr. John A. Drew; (18) Dr. T. K. Gruber; (19) Dr. W. G. Neally; (20) Miss Grace McElderry; (21) Miss Grace Reeder; (22) E. I. Erickson; (23) Dr. Walter E. List; (24) Dr. Nathaniel A. Faxon and James U. Norris; (25) Robert E. Neff; (26) James R. May; (27) Dr. M. Z. Westervelt; (28 Capt. H. H. Warfield and Charles F. Neeryaard.

country only 650 have been approved for internships. It also showed that the shortage of interns numbered 750 at the present time. Although eleven out of eight medical schools are trying to solve the problem by extending the course another year, giving the student that year for internship, the council on medical education does not believe that this is practical for universal adoption. The committee suggested a conference of all interested in the problem to come to some agreement as to what constitutes an acceptable internship, what the form of service should be, rotating or a continual service, and what is the best means of overcoming the shortage.

The report of the committee on foods and equipment for food service was read by Dr. F. R. Nuzum, director, Santa Barbara Cottage Hospital, Santa Barbara, Cal. The report brought out the relative merits of the central kitchen as contrasted with floor diet kitchens and the amount of time actually saved by various devices, such as dish washing machines, and certain vegetable utensils. The report was referred to the dietetic section Wednesday afternoon for discussion.

The prize architectural plans for a small hospital were featured at THE MODERN HOSPITAL's booth.

Reports Referred to Special Sections

Dr. Henry Hedden, superintendent, Methodist Hospital, Memphis, Tenn., outlined the report of the committee on clinical and scientific equipment and supplies which was referred for discussion Wednesday evening.

The special report of the subcommittee on x-ray departments and work was not read, as the chairman, Mr. Louis R. Curtis, vice-president, St. Luke's Hospital, Chicago, Ill., was unable to speak.

Dr. A. B. Denison, director, Lakeside Hospital, Cleveland, Ohio, chairman of the special committee on gauze renovation, announced that the committee would show its work in the exhibit at its booth.

As chairman of the committee on laundry, equipment and supplies, Dr. W. P. Morrill, superintendent, Shreveport Charity Hospital, Shreveport, La., commented to the effect that the work of the committee had only been started. The report was referred to the administration section Wednesday afternoon.

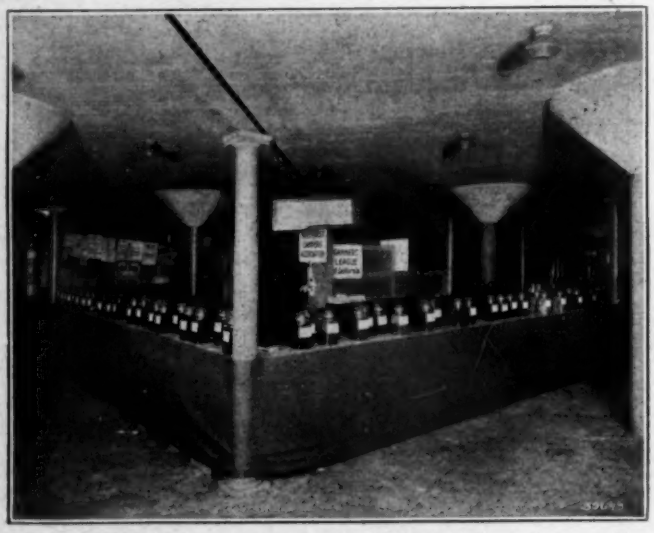
Work Toward Bed Standardization

The report of the committee on general furnishings and supplies was read by its chairman, Miss Margaret Rogers, superintendent, Lafayette Home Hospital, Lafayette, Ind., who outlined the work which the committee had done toward bed standardization in collaboration with the division of simplified practice of the department of commerce.

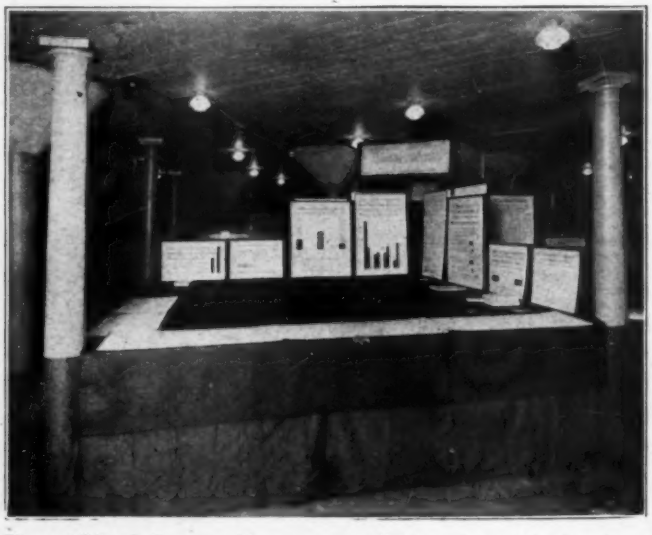
Dr. Alec M. Thomson, chairman of the committee on out-patient work, commented upon the attention which their work had been given by health officers of the country. The report was discussed at the out-patient section of the afternoon session.

The report of the committee on training school budgets was read by Dr. George T. O'Hanlon, chairman, superintendent, Bellevue and Allied Hospitals, New York, N. Y., who outlined the survey plans of the committee and presented a chart showing the distribution of the budget in Bellevue and Allied Hospitals, New York, N. Y.

Dr. George F. Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man., presented the report of the nominating committee. The following persons were nominated: president, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill.; first vice-president, J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas; second vice-president, C. W. Munger, Blodgett Memorial Hospital, Grand Rapids, Mich.; third vice-president, Emily Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore., and treasurer, Asa S. Bacon, super-



A view of the display of canned goods at the exhibit of the committee on canned fruits and vegetables.



The exhibit of the committee on out-patient work contained a large collection of charts showing the growth of dispensaries.

intendent, Presbyterian Hospital, Chicago, Ill. The following trustees were nominated: Miss Alice Thatcher, Christ Hospital, Cincinnati, O., and Dr. A. K. Haywood, superintendent, Montreal General Hospital, Montreal, Que.

A preliminary statement was made by Dr. C. W. Munger on behalf of the committee on cleaning.

Outlines Hospital Work by Women

The only paper presented at this session was that on "Woman's Work in Hospitals," by Mrs. Perkins B. Bass, president, woman's auxiliary board, Presbyterian Hospital, Chicago, Ill., who made a few introductory remarks, but gave her paper to Mrs. Carey Culbertson, also a member of the board, to read. In the paper, Mrs. Bass outlined the scope of work which women can accomplish in the hospital with special reference to what her board had been doing. She brought out strongly that an organization of women should set out to accomplish a definite piece of work. She outlined the types presented in the fields of hospital social service, occupational therapy work, the encouragement of training schools, the establishment of chorus work, the accumulation of funds for free beds, endowments and scholarships for graduate nurses, and hospital library work. She emphasized, particularly, what service a woman's auxiliary board or similar organization can do in the way of interesting the children of the community.

Booth where the treatment of insulin was demonstrated. These nurses from the Royal Victoria Hospital, Montreal, told the eager visitors about insulin.

Boards Need Sympathy Plus Wisdom

Following the paper by Mrs. Bass, President Bacon invited Mrs. David W. Graham, Chicago, Ill., a charter member of the woman's auxiliary board, to say a few words. Mrs. Graham commented upon Mrs. Bass' paper, strongly emphasizing what care was needed in the organization of woman's auxiliary boards, and the necessity for cooperation of individual members as well as departments of the hospital. She said that the financial aid which such a board can be to the hospital cannot be overestimated. She brought out what such a woman's organization can do in the way of assisting the superintendent of nurses, and stressed the need for wisdom in the sympathy which women extend to the patients in the hospital.

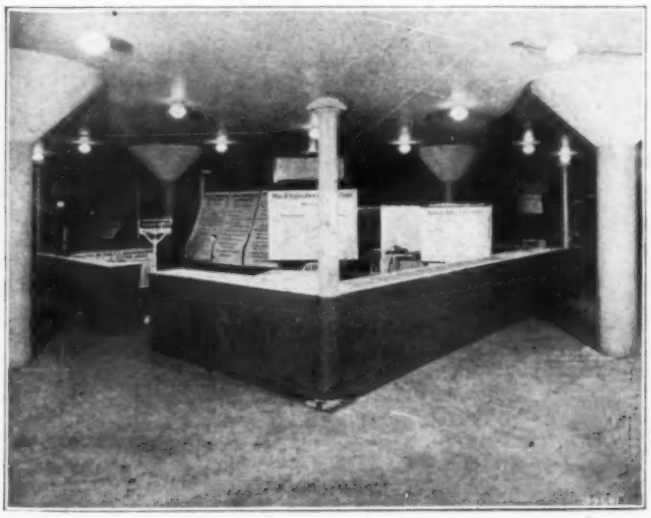
A motion was made from the floor and carried, that the paper by Mrs. Bass and the talk by Mrs. Graham be printed by the association.

An insight into the workings of the dispensary both from the viewpoint of the medical directors as well as from that of the patients was gained from the program of the out-patient section held Tuesday afternoon. Dr. Alec M. Thomson, medical secretary, committee on dispensary development, New York, N. Y., presided. Before presenting the two speakers of the afternoon, Dr. Thomson briefly discussed the report of the out-patient committee, stating that the committee merely included in the report the work which had been done the past year in correllating the material from the various New York dispensaries. He called attention to the widespread conception of the dispensary as an important factor in preventive medicine. He brought up the question of health examinations as insurance for well persons and asked if they were such, should they not be paid for by the patient.

"A Pay Clinic" was the subject of the first paper of the session which was read by Dr. George Hoyt Bigelow, director, Cornell Clinic, New York, N. Y.

The Pay Clinic

The "Inside" story of a pay clinic was told by Dr. George Hoyt Bigelow, director, Cornell Clinic, New York,



These charts which line the exhibit of the association for the prevention and relief of heart disease show what is being done in that work.

This booth which contained an abundance of pictures and plans for the building of tuberculosis sanatoriums attracted many visitors.

N. Y., in his paper "Organization and Administration of a Dispensary."

Dr. Bigelow said that the rich and poor have potentially the best medical service if they only know where to get it, and that the pay clinic is an effort to put the same potential service within the reach of persons with restricted incomes. The pay clinic, he believes, will disprove the prevalent misconception that in accord with the present trend of medical science, adequate service can be afforded only by the rich.

Rates Based on Cost of Service

In discussing the problem of the charge made to patients, Dr. Bigelow made special reference to the Cornell Clinic where it is not feasible to vary the charges to the patients directly according to the cost of the service rendered, as there is too wide a variation and too great a multiplicity. The rates of compensation to the doctors also have a very direct bearing on the cost of the service rendered, according to Dr. Bigelow.

Dr. Bigelow said that the Cornell Clinic was criticized in the daily press for excluding anyone who can meet the first admission fee and told that the financial inquisition to which we submit patients is undemocratic and un-American. He said that the system used at the Cornell clinic was drawn up by Cornell authorities and the committee on dispensary development in consultation with two professors from Columbia University. The system admits single individuals with annual incomes of eleven to eighteen hundred dollars up to a family of five earning three thousand. Two hundred is allowed for each individual member. Dr. Bigelow said that probably the greatest single factor at Cornell that has gone toward the improving of the service is the appointment system which has limited the capacity of the clinic.

He concluded by saying that the amount of data bearing on the questions that are of the most vital and immediate interest to the community as a whole together with the medical profession from such an experiment is an overwhelmingly sufficient reason for the conduct of such an experiment.

The subject of medical relationships in a dispensary was presented by Dr. A. B. Denison, superintendent, Lakeside Hospital, Cleveland, Ohio, as the closing paper of the out-patient section of the Tuesday afternoon program.

Doctors and the Dispensary

"The problems of dispensaries," said Dr. Denison, "are so very individual, and peculiar to each dispensary that it would be sheer folly to attempt to propose a general solution for dispensary problems of medical relationships. Each dispensary must approach its problem in the light of local conditions and with a clear conception of the materials with which it must work."

Dr. Denison pointed out that the degree of cooperation secured from the medical profession is dependent very largely upon the attitude of the hospital in approaching the medical group. He cited the Lakeside night pay clinic which was recently reorganized as a case where it had been proved that the problems previously considered to be the province of either the hospital or the profession were susceptible of joint action, and that the results were unmeasurably more satisfactory to all concerned. The constant cooperation of the Cleveland Academy of Medicine with the hospital is indicative, he said, of what can be expected when the medical profession is merely given the opportunity of a fair-minded cooperation.

Medical Relationships Secondary

"The medical relationships in a dispensary," he said, "are secondary to, and follow the insuring of mutual confidence and esteem and once these are established the lid is off and the sky is the limit to the achievements possible to the cooperating profession and hospitals."

In the discussion which followed these papers, John E. Ransom, superintendent, Michael Reese Dispensary, Chicago, Ill., called attention to the standards set up by the out-patient report and suggested that the committee give attention to the proposition of what constitutes adequate medical service in a dispensary and by what means it can be accomplished.

Representative groups of Sisters on their way to the auditorium. The Sister in the center of the group (above) is Sister Rose Alexius who read a paper on "The Heart of the Hospital."

Mr. Frank E. Wing of the Boston, Mass., Dispensary, touched upon the increased service which pay clinics are offering in the way of general physical examinations to well persons. He pointed out the lack of machinery for medical responsibility in follow-up work. He also said that much valuable time is lost in many dispensaries because of a lack of a general physical examination upon the entrance of the patient who comes for the treatment of a special ailment.

Architectural Slides Shown

The section on hospital construction Tuesday afternoon was presided over by Mr. E. S. Gilmore, who introduced Mr. John Holabird, architect, Chicago, a graduate of the Beaux Arts of Paris. Mr. Holabird gave a talk on architecture, illustrating it by a number of slides, showing notable examples of Greek, Roman, French and English styles. He divided his talk into three parts, speaking on what architecture comprises, the esthetic side of architecture, and how the owner can assist the architect. He dwelt, however, chiefly on the esthetic side of architecture, this being the aspect of the subject which he feels calls for more general attention.

"The buildings of twenty years ago," said Mr. Holabird, "were loaded with ornament and look incongruous beside the simpler buildings of today, but the evolution of a style is a long affair." He feels that the skeleton construction seen in America today is the only radically different style in architecture since the time of the Gothic. This has created an American style, he said, and it is now a question of properly clothing our skeleton structures. When this has been accomplished our ornament as well as our form will be truly American.

He mentioned four hospitals which he considers have fine exteriors: Fifth Avenue Hospital, New York, N. Y., in the Italian style, Boston Lying-in Hospital, Boston, Mass., also Italian in design, Grasslands Hospital at East View, New York, in the colonial style, and the hospital for the University of Illinois, which is collegiate Gothic. Mr. Holabird feels that superintendents of hospitals and members of boards of trustes should strive to assist the architect and should themselves give a reasonable amount of study to the question of style, proportion, materials, and be in a position to offer constructive criticism.

Following Mr. Holabird's talk, the discussion of the second report of the committee on floors was by Mr. F. E. Chapman, director, Mount Sinai Hospital, Cleveland, Ohio. Mr. Chapman reviewed the pertinent points in the committee's report of last year and referred to the fact that from 1,200 questionnaires which the committee sent out in an effort to gather opinions on the subject of flooring for hospitals, only 19 replies were received. From this it was gathered that there was a general lack of knowledge of this subject or a lack of interest in it. Mr. Chapman then enumerated the prerequisites for satisfactory flooring as given in the committee's report and also gave the basis for analysis under a number of different headings.

Mr. Edward L. Farr, president, Cooper Hospital, Camden, N. J., spoke of his experience with linoleum and similar products which, he feels, have a very distinct place in the hospital, particularly in dining rooms and private rooms, and may be used with varying degrees of success in every department of the hospital except the operating room. Mr. Chapman stated, in reply to questions on the subject, that linoleum has been shown by tests to have a low fire resistance and that it is rather easily stained, some stains being easily removed while others are absorbed.

The report of the committee on buildings, construction, equipment and maintenance, in the absence of Chairman S. S. Goldwater, M. D., director, Mount Sinai Hospital, New York, N. Y., was read by Mr. James R. Mays, superintendent, Garfield Hospital, Washington, D. C. A number of architects and others spoke, emphasizing the value of Dr. Goldwater's report and advocating careful study of its many interesting and constructive features. Mr. Perry W. Swern, architect, Chicago, remarked on the amount of attention that is being given to keeping down building costs and the many suggestions offered toward this end. If the system of planning by measured circulation works out, it will revolutionize the hospital ideas of the past, Mr. Swern said and advised every superintendent to look into this system.

Architects Discuss Building Report

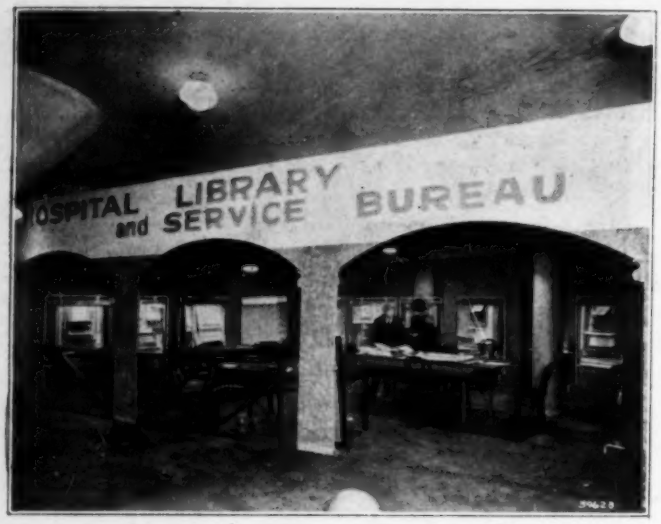
Mr. Edward F. Stevens, architect, Boston, Mass., called attention to the importance of the question of sound deadening, saying that much criticism is leveled at hospitals, especially new ones, on the ground that they are unnecessarily noisy. He referred to the subject of the private room versus the ward, and felt that we are getting toward the small ward, with screens separating the beds, insuring a certain degree of privacy. Concentration of units is called for rather than a spreading out. Mr. Charles Butler, architect, New York, N. Y., said that in ordinary hospital work he had found that the use of stucco on cheap brick effected a considerable saving in cost, providing the building was not more than four stories high; with higher buildings the expense of scaffolding counteracted any saving. Dr. R. G. Brodrick, director, Alameda County Hospitals, San Leandro, Cal., stated that the most perplexing thing to him in hospital construction matters was the operating room lighting, particularly the fixtures in operating rooms. Dr. Brodrick feels that we must not get economy of construction at the expense of proper hospital service. Mr. Charles E. Neergaard, trustee of Brooklyn Hospital, Brooklyn, N. Y., expressed the opinion that in the past the planning of hospitals has been too largely guided by theory and tradition rather than by good economical practice.

Dr. W. C. Babcock, superintendent, Grace Hospital, Detroit, Mich., said he was glad to note the preference expressed in the committee's report for brick and steel construction as compared to concrete reinforced, and strongly advised small hospitals to employ a special hospital consultant. Dr. Robinson, Cincinnati, Ohio, said that people must be educated to understand that a hospital is not a cheap proposition. We must make no concessions to lower prices, but must use the best and leave out nothing that will contribute to the most efficient care of the sick. Others who contributed to the discussion were: Dr. Young, Chicago, Ill., Olof Z. Cervin, Rock Island, Ill., Dr. Walter Conley, New York, N. Y., Mr. Meyer Sturm, Chicago, Ill., and Mr. Henry C. Wright, New York.

Chicago Health Commissioner Speaks

The general session Tuesday evening was opened by Dr. Herman N. Bundesen, commissioner of health, Chicago, Ill., who spoke on "Responsibilities of Hospitals Toward Public Health Activities."

"Diseased conditions," said Dr. Bundesen, "must be exposed to the cleansing light of universal knowledge, as they maintain themselves almost entirely on public ignorance. There should be complete cooperation between health departments and hospitals for it is through the work of the hospital staff that there comes to the health departments the knowledge they need to have for the



The racks along the walls are filled with 600 sets of floor plans and all sorts of material collected about the hospital field which made up the extensive exhibit of the Hospital Library and Service Bureau.

prolongation of life. The community that has a low death rate has good hospitals."

The report of the Hospital Library and Service Bureau, in the absence of Miss Donalda Hamlin, director, Chicago, Ill., was presented only by title.

Goitre Problem in Chicago

A recent survey, he said, has shown the city of Chicago to be one of the worst goitre belts in the world today. It is a public health problem, for thousands of little children suffer from goitre which could be prevented, for goitre is absolutely preventable.

Speaking of cancer, Dr. Bundesen said that here the solution is the hospital. Were cases taken there early for diagnosis and treatment there would be a marked improvement.

In regard to social diseases, he feels that hospitals are not doing their part. The majority of them shrink from and neglect the problem, which he stated is the great menace to American civilization today. It is vital in his opinion that hospitals face this situation and that a venereal disease ward be established in every hospital.

Superiority of Ethylene

A paper on "Ethylene" was given by Dr. Arno Benedict Luckhardt, chairman, section on pathology and physiology, American Medical Association, Chicago, Ill. Dr. Luckhardt outlined the various tests that have been made in the use of ethylene, which is becoming one of our greatest anesthetics. He said that tests were made on plants, frogs, white mice and rats, guinea pigs, kittens, dogs and finally on human beings. It was found that anesthesia can be rapidly induced by ethylene, without discomfort, that the treatment is not unpleasant and that there is little nausea. Experiments were first performed on normal men, next on patients and surgical work was then begun at the Presbyterian Hospital, Chicago. A striking feature in the use of ethylene was found to be the absence of gas pains. Dr. Luckhardt's paper was discussed by Dr. Isabella Herb who has had much experience in administering ethylene as an anesthetic at the Presbyterian Hospital, Chicago. She said there is now a record of 958 anesthesias with no deaths. Age and sex of patients seem to make no difference, according to Dr. Herb, the youngest case treated being four years old and the oldest eighty-eight years. Nor do habits, such as drug habits, have any noticeable effect. No pre-medication is given and relaxation is found to be better than where nitrous oxide is used. Dr. Herb said that ethylene has been used where there was heart trouble and no evil has resulted from the anesthesia. She also maintains that ethylene is safer than nitrous oxide because one can give more oxygen with it. With regard to its inflammability, it is not as dangerous as ether or as a combination of nitrous oxide and ether which is highly combustible. In answer to a question, Dr. Herb stated that any gas machine which delivers nitrous oxide will deliver ethylene.

Mr. Charles H. Pitcher, superintendent, Presbyterian Hospital, Philadelphia, spoke on the subject of "How to Teach the Value of Supplies and Equipment to the Hospital Personnel," which appears in full on page 507 of this issue.

Wednesday morning's general session was opened with a paper on "The Responsibility of Hospitals in Minor Operations," by Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich.

Responsibility in Minor Operations

That all so-called open hospitals should develop definite high class standards of surgical, obstetrical, and medical practice and require all physicians who send patients to the hospitals, to meet a high average of professional efficiency, was stressed by Dr. Warren L. Babcock, director Grace Hospital, Detroit, Mich., in his paper, "Responsibilities of the Hospital in Minor Operations and Other Professional Activities."

In the case of closed hospitals, Dr. Babcock said that with a limited attending staff, a standardized procedure in pre-operative and post-operative care as well as obstetrical practice, has limited the number of accidents that occur as a result of diverse practice or lack of routine procedure. Dr. Babcock brought out that no open hospital also could properly function without giving due thought and attention to the methods of surgical and obstetrical preparatory procedure and after care. He believes that hospital authorities in addition to ascertaining the standing of the practitioner through special inquiries, should in all cases closely supervise his surgical operative work, or his obstetrical and medical practice until satisfied that the physician or surgeon is a safe and reliable man, both in judgment and methods.

In speaking of the responsibility of the hospital in

This large assortment of posters and publicity notices about National Hospital Day gathered from all parts of the continent filled the booth of National Hospital Day.

regard to the administering anesthesia, Dr. Babcock said: "A hospital that does not avail itself of the best talent in anesthesia training and service is indifferent to its responsibilities to the public. Highly trained anesthetists or supervision of competent anesthetists is absolutely necessary to safeguard the reputation of the hospital."

Standardize Routine Work

Dr. Babcock strongly advocated that nose and throat departments and surgical and obstetrical as well as other specialties should publish standardized methods of procedure for routine work. In surgery, he said that this should cover the pre-operative period and the preparation of the patient for operation as well as the post-operative care of the patient for such a period of time as the patient may be subjected to danger from the operation. In all cases of nose and throat operations, he said that a throat culture should be taken within twenty-four hours of the operation and negative report presented before preparation for operation is made. He urgently advised that all patients for minor operations should enter the hospital the preceding afternoon so that a preliminary examination could be made.

Dr. Babcock closed his paper by presenting the house orders of Grace Hospital for various departments, and the various types of surgical cases.

Why Hospital Insurance?

Dr. Babcock was followed by Mr. Frank G. Watson, Chicago, Ill., who presented a paper on hospital insurance. "Insurance is a business stabilizer," said Mr. Watson, "without which the greater material development of this country would have been impossible." Mr. Watson pointed out the factors which are peculiar to hospital insurance and advised hospital executives to place the management of their insurance in the hands of a competent broker. In speaking of the great fire hazard which still menaces hospitals, Mr. Watson said that a hospital burns every day and that this deplorable thing should and could be prevented by proper construction of buildings and by the introduction of safety devices in addition to the careful inspection which is afforded by the insurance companies. He urged superintendents to look upon insurance as a service and for them to claim and get that service which insurance companies are ready to offer.

In discussing Mr. Watson's paper, Mr. Daniel D. Test said that many Pennsylvania hospitals do not have insurance because the supreme court of that state has ruled that hospital funds are trust funds and may not be diverted in the way of investing in insurance. A representative from Massachusetts brought out that the laws of that state are such that very few hospitals carry liability or mal-practice insurance. Dr. George Stephens raised the question of how extensive group life insurance should be among employees and on what basis it should be paid. Mr. Watson was unable to give a definite answer to this question.

These charts and maps in the background were the source of much interest and study for the social workers who hovered about the booth of the American Association of Hospital Social Workers

An extensive array of posters descriptive of hospital library service from hospitals all over the country comprised the exhibit of the American Library Association.

Education of Hospital Executives Discussed

The report of the committee on the education of hospital executives was outlined by Dr. Willard C. Rappleye, superintendent, New Haven Hospital, New Haven, Conn., in the absence of Dr. F. A. Washburn, chairman. Dr. Rappleye pointed out that the functions of the committtee were to attempt to stimulate certain sections to establish training centers for hospital executives, to act as an advisory board in promoting the establishment of hospital executive courses in universities, and in mobilizing opinion on the subject. He said that the most important phase of the problem was that of securing the right type of student and that the committee was making an effort to secure prospective students as hospital executives.

Non-Medical Aids Instead of Interns

Dr. A. R. Warner read the report of the delegate to the American Conference on Hospital Social Service which brought out the problem of intern shortage and presented the solution recommended by Dr. S. S. Goldwater, which is that of training non-medical and clinical aids. This would reduce the number of interns needed in these hospitals. The budget of the Hospital Library and Service Bureau calling for an annual appropriation of $30,000 for three years and also a budget, not yet fully arranged, for the promotion of non-medical clinical assistants was reported as approved by the Conference on Hospital Social Service.

Hospital Team Work

"Team Work Among Hospitals," a paper by Mr. W. J. Raddatz, Hospital Council, Cleveland, Ohio, was read by Howell Wright, in the absence of Mr. Raddatz. Mr. Raddatz traced the development of the hospital as a com-

munity benefactor directing attention to the increased business problems which arise from the growing complexity of the modern hospital. He particularly stressed the social development of the hospital and the responsibility which such institutions owe to the community and the public not only in the care which they give to their inmates but as teachers of public health and leaders in preventive medicine. "The modern hospital," said Mr. Raddatz, "is merely a medical means to a social end and that end—public welfare—must never be forgotten."

"This is the day of group action," Mr. Raddatz said, "and there are certain definite principles for the expression of group interests which should be understood and applied in the hospital field." He pointed out that hospitals had been unusually slow in organizing to keep themselves, their trustees, and controlling officers informed through a central organization. He directed attention to the hospital council movement which is making progress in several cities and advocated a greater development of group hospital interests in cities and in states.

He made reference to the Cleveland Hospital Council with which he is intimately acquainted and enumerated some of the results which the hospitals of that city have gained through this organization. Better hospital accounting has been brought about which, in Ohio, has resulted in the individual agreement between the state industrial commission and the individual hospital for service rendered to the injured on the basis of "cost".

Other improvements which the council has effected are: (1) the enactment of legislation for the furtherance of the common good through hospitals; (2) organization of the purchasing service; (3) organization of the collection service; (4) a hospital and health survey; (5) better cooperation of trustees and executives through the community fund and the welfare federation in its centralized money-raising.

The program was concluded by a few remarks from Mr. Richard P. Borden, chairman of the committee on constitution and rules and of the committee on resolutions who exhorted the assembly to preach the gospel of healing to all parties interested in the world, and encouraged trustees to extend as far as possible the privileges of membership. He presented the proposed amendment to article 3, section 4 of the constitution which states that any person not residing on the continent may become a subscribing member entitled to privileges of the association. It was announced that the amendment would be voted upon later.

The program of the administration section Wednesday afternoon was one of discussion of reports of different committees appointed by the section. Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, chairman of the committee on forms, the first speaker, stated that the report submitted this year had practically nothing to do with forms, no changes having been made in the recommendations pertaining to forms made by the committee at the convention two years ago. Dr. Bachmeyer feels that interest does not center so much in the use of particular forms as in having the principles enumerated in the report recognized and adopted.

Two representatives of deaconess' hospitals who attended the convention.

Advocates Bookkeeping Machines

A great variety of questions are received by the committee, the answers to some of which are given in the report, the last part of which deals with current financial reports. Mr. W. D. Clark, assistant controller of the University of California, the next speaker, pointed out one thing in connection with the report that might be overlooked, that is, the fact that no amount of forms will get the results that the director of a hospital requires unless the budget system is operated by a competent accountant. Mr. Clark advocated the use of bookkeeping machines which, he said, give great satisfaction and decrease the volume of work to be done. The low cost of these machines and their simplicity of operation have put them within the reach of even the smaller hospitals. A motion was made and seconded from the floor that the report be accepted and this was approved by the meeting.

Combination of Interests Suggested

Dr. W. P. Morrill, chairman of the committee on laundry equipment, supplies and linens, was next called on to speak on the report of this committee. The report, Dr. Morrill said, is a continuation of the work of last year, with some added detail on the washing process. He pointed out the need for some joint action so that an agreement might be arrived at whereby the manufacturers of textiles would bring their products up to a certain standard. A combination, he said, of those interested in textiles, with the American Hospital Association, the Hotel Association and the Laundry Association, whose interests are practically the same, could bring sufficient pressure to bear on certain textile manufacturers to get more uniformity of output from them. In discussing the report, Mr. Richard P. Borden said that the hospitals rather than the manufacturers have to decide the kind of cloth that is needed. If the hospitals can pick out the most desirable type of gauze and cotton the manufacturers will produce something which will conform to the standards set up. Mr. Asa S. Bacon pointed out that the household committee is at work on this problem and that beds must first be standardized, and that later will come the standardization of linens.

Dr. A. C. Bachmeyer, superintendent, Cincinnati General Hospital, Cincinnati, Ohio, moved that the report be accepted and referred to a general session for

adoption; the motion was seconded and approved.

Dr. A. B. Denison, director, Lakeside Hospital, Cleveland, Ohio, chairman of the committee on gauze renovation and standardized dressings, said that the committee was designed to collect and correlate information which would embody the opinions of the largest possible group of hospital people. The report, he said, is presented as a suggestion and represents the opinions of but a limited group of people; the chief object of the committee is to get additional information from more sources.

Mr. H. E. Webster, superintendent, Royal Victoria Hospital, Montreal, with Mrs. Webster and the two nurses, Miss H. Moser and Miss M. E. Pickard, who were in charge of the insulin booth and demonstration.

Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, Ill., led the discussion on renovated gauze versus non-renovated gauze, saying that if the dressings are to be washed a better type of gauze must be used which increases the initial cost and, in some cases has been found to effect no saving. Dr. George A. MacIver, assistant director, Massachusetts General Hospital, Boston, Mass., said that twenty years ago the practice of reclaiming gauze was instituted at his institution and has been continued with absolute satisfaction. Mr. E. E. Dickson, New Brunswick, N. J., speaking from the manufacturer's point of view, said that the hospital must decide what grade of gauze is best for individual dressings and whether or not the gauze is to be washed. If the manufacturers can find out definitely what is wanted they are ready to do their part, but first specifications must be drawn up. Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich., spoke in favor of washed gauze, as did also Dr. L. H. Burlingham, superintendent, Barnes Hospital, St. Louis, Mo.

A motion was made, seconded and approved that the board of trustees be requested to continue this committee for further investigation of this important subject.

Committee on Cleaning to Continue Study

The next report to be discussed was that of the committee on cleaning, of which Dr. C. W. Munger is chairman. Dr. Munger said the committee was not putting forward a report but a preliminary statement, outlining the work which the committee hopes to do. A study will be made of the cleaning of floors, windows, rugs, instruments and the washing of dishes. Dr. W. L. Babcock, superintendent, Grace Hospital, Detroit, Mich., said that the report, not being a definite one, was too intangible for discussion. He suggested that the committee might be able to get expert assistance and advice from the manufacturers of various commodities which require cleaning in a hospital as manufacturers make experiments in cleaning their products. Dr. Babcock feels that the subject of polishing, as well as that of cleaning, should be taken up by the committee. He mentioned the fact that much economy can be brought about by the manufacture of soft soap in the laundry of a hospital and that a good material can be made with great ease, if proper methods are used.

The report of the committee on clinical and scientific equipment and supplies was briefly discussed at the administration section, Wednesday evening, by Dr. Henry Hedden, superintendent, Methodist Hospital, Memphis, Tenn.; chairman of the committee, Dr. E. R. Crew, superintendent, Miami Valley Hospital, Dayton, Ohio, and Mr. W. W. Rawson, superintendent, Thomas D. Dee Memorial Hospital, Ogden, Utah. The report deals almost entirely with sterilized equipment. The different speakers related experiences they had with their respective institutions with regard to the sterilization of equipment showing how different are the conditions to be faced in different hospitals. Mr. Rawson emphasized the fact that a thorough investigation should be made of equipment it is proposed to purchase, and said that superintendents should satisfy themselves that what is bought is suited to the particular needs of their institutions, and should also see to it that proper care is taken of the equipment after it is installed. He feels it is a good plan to have a mechanic inspect the equipment every day.

Mr. Louis R. Curtis, vice-president, St. Luke's Hospital, Chicago, Ill., in discussing the special report of the subcommittee on x-ray department work, said that this is a department which has not had due consideration in hospitals and that the status of the roentgenologist has not been well defined. Mr. James R. Mays, superintendent, Garfield Memorial Hospital, Lafayette, Ind., expressed the same opinion, saying that hospital administrators should place the x-ray laboratory on a higher plane than has been accorded it in most institutions.

Mr. S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., advocated the employment of a competent roentgenologist on full time in the x-ray department and made a plea for low charges for x-ray work so that it may be within the reach of the ordinary hospital patient to whom it is a diagnostic aid. A motion was made that the report be accepted and referred to the trustees; the motion was seconded and approved.

Miss Margaret Rogers, chairman of the committee on general furnishings and supplies, said that the report of her committee was preliminary and not final and that a great deal more information was required from hospitals in order to complete the report. Three hundred and sixty-five replies had been received in response to the questionnaire sent out by the committee but of these 101 could not be used because the information was incorrect and was received too late. A motion was made that the report be referred to the trustees with a recommendation that the committee be continued for the purpose of making a further report.

Dr. George T. O'Hanlon, chairman of the committee on training school budgets said that the committee, was appointed recently and did not have an opportunity to make a survey. Training schools in the East, he said, seemed to be taking an interest in the budgetary system for their schools, but schools and hospitals are so closely connected that it is difficult for many of them to arrive at a definite expense account for their schools. Dr. O'Hanlon feels that if the budgetary system is to be operated there

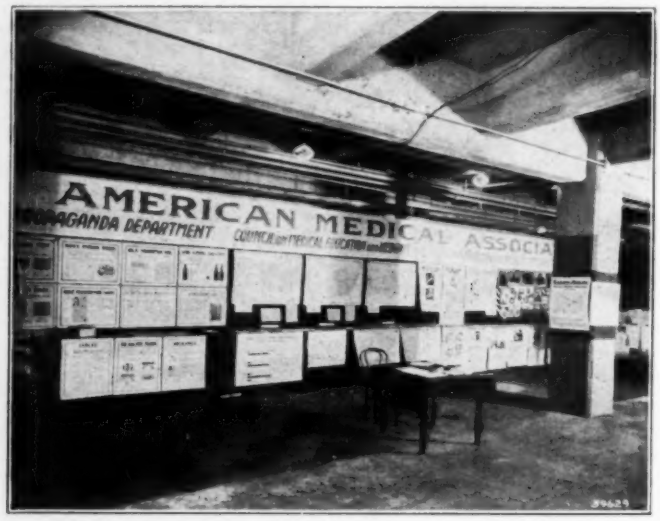
must be cooperation from everyone who has to do with the expenditure of money in the hospital. The committee, he said, will have something to present next year in the way of suggestions and would meantime be glad to have suggestions from hospitals as to what is wanted.

A motion that the report be referred to the board of trustees with the request that it be continued for a further report was unanimously carried.

Dietetic Session

The session which the Hospital Dietetic Council had in conjunction with the conference was held Wednesday afternoon in Englemann hall. Miss Lulu C. Graves, supervising dietitian, Mount Sinai Hospital, New York, N. Y., was chairman. The first part of the session was taken up with the discussion of report of the committee on canned fruit and vegetables by Mr. Guy J. Clark, chairman, Cleveland Hospital Council, Cleveland, Ohio, who outlined what had been accomplished by the four leading canning sections of the country in the way of adopting standard specifications.

This was followed by a discussion of the report of committee on foods and equipment by the chairman, Dr. F. R. Nuzum, medical director, Santa Barbara Cottage Hospital, Santa Barbara, Cal. The relative merits of a central kitchen as contrasted with floor diet kitchens was one of the interesting points brought out in the discussion. Attention was drawn to a number of time-saving devices and the necessity of hospitals offering courses in dietetics.



What the American Medical Association is accomplishing in its various departments was well represented in the posters and displays of this exhibit. Posters showing what is being done to combat frauds and quacks as well as their new magazine Hygeia attracted wide attention.

Two papers were presented at the session, one on "A Consideration of Diets for Patients Receiving Insulin," presented by Dr. S. Franklin Adams, Mayo Clinic, Rochester, Minn., and one on "Adapting Diets to Individuals" by Miss Berta M. Wood, East Northfield Seminary, East Northfield, Mass.

Approve Old Age Pensions

The trustee section met in Engelmann Hall on Wednesday evening under the chairmanship of Mr. Alfred C. Meyer, president, Michael Reese Hospital, Chicago, Ill. In the absence of Dr. Robert J. Wilson, director of hospitals, department of health, New York, N. Y., Mr. Asa S. Bacon, president of the association, commented on the report briefly, pointing out that the committee approved old age pensions for hospital superintendents in principle, but felt that the association at present could do little more than issue information on the subject from time to time and urge trustees to establish individual pension funds in their hospitals. Attention was called to the fact that such a fund has been in existence for some time at the New York Hospital.

Mr. Meyer then presented a digest of opinions on the handling of endowment funds (See page 510).

"The real endowment of an institution might well be not only money but desire and ability to meet fresh needs as they come, to set new standards in succeeding generations," said Mr. Edwin R. Embree, secretary, Rockefeller Foundation, New York, N. Y., in his paper "Benefits and Disadvantages of Endowments for Hospitals."

Hospital Endowments

Mr. Embree pointed to the old hospitals, such as St. Thomas' and St. Bartholomew's London, which he said are indicative of the firmly established place which hospitals have in the life of civilized peoples and illustrate what endowments, retained and added to from age to age may do in preserving worthy institutions. "They made it clear," said Mr. Embree, "that foundations in wise hands guided by intellectual resourcefulness and imagination, may adapt themselves to new needs, may continuously raise their standards and revise their methods in meeting the new demands of succeeding generations. These are elementary and fundamental considerations with respect to hospital establishments."

In the other direction, Mr. Embree pointed out the danger of the tendency to assume that the raising of funds, the accumulation of large endowments are the all important functions of hospital trustees. The prime emphasis, he said, should be given by trustees not to the amounts of money which they can raise but to the uses to which these sums are placed. He also cited examples to show that the physical richness of an institution is not indicative of its services to the community.

Mr. Embree drew attention to the importance of expending funds for preventive work saying: "Is it not better to exhaust all available funds in eradicating typhus in a district of the East than to preserve an endowment to give hospital care to continuing cases?"

General Methods of Financing Given

The general methods of financing funds for the hospital in wide use were given by Mr. Embree as the restricted endowment, and the general endowment providing perpetually for the entire needs of an institution. He did not advocate either method specifically, but emphasized that endowments were of value only as they guarantee that enrichment of the community for which hospitals are created.

In the discussion of Mr. Embree's address, various delegates touched upon the necessity of establishing endowments in teaching institutions for laboratory work and research and for demonstrations of new methods, and the desirability of having the funds used for charitable work come from volunteer contributions or through community chests annually, rather than from endowments. It was also pointed out that each county could, if soundly organized, carry out its health program without outside aid. Small endowments for small hospitals were also advocated.

Widespread interest in nursing problems was evidenced by the large attendance at the nursing section Thursday

morning. Miss Evelyn Moore of the executive council of the nursing education, spoke on the work of the central council which has now a membership of thirteen hospitals. Through the distribution of literature it is attempting to promote high standards and to disseminate general knowledge regarding nursing. Miss Carolyn Martin, executive secretary of the council, told of her work in visiting high schools and colleges as a representative of the council. Miss Roberts, editor of the *American Journal of Nursing*, told the way in which the magazine was aiding the cause of education and had been working for higher standards throughout its twenty-three years of service.

In the absence of Miss Edna Foley, Visiting Nurse Association, Chicago, Ill., her paper on the opportunities of service offered to the graduate nurse, was read by Miss Laura Logan, Cincinnati, Ohio. The paper brought out that if the highest type of women are to be attracted into the profession there is need of a high standard of education. The student wants education to make her life complete. Attention was directed to the curriculum of the National League of Nursing Education which has been the guidepost of nursing schools since 1917 and to the placement bureau of that league which aims to put the right woman in the right place.

A view of the model kitchen showing the equipment of the main kitchen in the center and the dietary kitchen in the background.

A paper on the "Classification of Nursing Schools" was read by Miss Adda Eldredge, who made a few remarks on the problem from her experience. "Formerly, nurses were just trained to say, 'Yes, doctor,' and 'No, doctor,'" said Miss Eldredge, "but now through the persistent effort of those who are devoting themselves to the cause of nursing, their right to an education is slowly being recognized by the public."

In her paper on classification of nursing schools, Miss Gray dwelt on the educational results which such a classification of medical and nursing schools will bring. Through the statistics compiled by the Carnegie Foundation much light has been thrown on the whole situation. These show that over 11,000 nurses are in public health work and over 8,000 in administrative work, and that there are at present 800 schools of nursing with an enrollment of 54,000 students.

Miss Gray emphasized the need of a separate classification of hospitals according to the educational standards of nursing, and expressed herself in favor of permitting the Carnegie Foundation to go ahead with the work of classifying nursing schools. She said that the need for this classification was becoming more vital every year and that unless hospitals were able to put forth high educational standards they would not be able to attract the type of young women who are needed in the profession.

"Hospital Group Nursing," was the subject discussed by Sister M. Paul, St. Mary's Hospital, Rochester, Minn., in her paper on that subject. She outlined the features of this arrangement as it is in use at St. Mary's Hospital, showing the economy it effects, particularly where there is a shortage of nurses. By the group system she showed that the service is made cheaper to the patient and a saving is effected both in the living expenses of the nurse and in her physical conservation. The successful working of the system, she pointed out, depends upon the right selection of nurses and complete cooperation on all sides. She gave the following points as governing the adoption of this system: select your nurses wisely, explain the system to the patient upon entering the hospital, and make it known that the system is not a money making one. In the discussion which followed it was shown that the system appeals to the nurse herself.

Pleads for Health of the Nurse

"Health of the Student Nurse," was the subject of the outstanding address of the session, delivered by Dr. Carolyn Hedger, Chicago, Ill. "There is a direct conflict between the needs of the hospital and the health of the nurse," said Dr. Hedger, and she directed attention to the phases of the problem with which nursing schools are confronted. She regretted that at the present time it is impossible to find out what it costs the hospital to educate the nurse. In her work in various Chicago hospitals she was able to glean a few figures which are indicative of what it costs various sized hospitals, but no definite conclusions can yet be drawn from these figures because of the lack of systematized cost accounting. She told superintendents that in reckoning the cost of the nurse they should evaluate the worth of the nurses' services throughout the entire period with the hospital and also what the sick days of nurses cost the institution. She said that this item was so great in many of the hospitals that she had found one school of 140 nurses which had to carry seven extra nurses all the time to offset the time lost by illness.

Another factor which she considered of vital importance is the labor overturn of nurses, and she said that health was a big reason for the loss of many of the nurses during their first few months in the hospital. She believes that a great deal can be done by hospitals through preventive measures to combat certain diseases which have prematurely driven many students from continuing nursing. She deplored the idea that there is not one word of health in the organized curriculum and said that right away we must have the teaching of health, not through theoretical courses, but by sending the nurse out with the right concept of health to which her other training can be attached. In addition to inculcating the concept of health, Dr. Hedger gave as the three other essentials, nutritional supervision, conservation of the reproductive functions of the nurse, and conservation of the nurse's nervous vitality.

Through her wide experience in visiting hospitals she showed examples which prove that these four factors are at the bottom of the difficulties which constitute the nursing problem of today. She strongly advocated the use of the Schneider Cardiovascular Test as a measure of the

fitness of the nurse and advised the regular examination of nurses once a month.

On Thursday morning the administrative section held a meeting on public health and community relations under the chairmanship of Dr. T. K. Gruber, superintendent, Receiving Hospital, Detroit, Mich. Following a brief statement by Mr. John E. Ransom relative to the method of compiling data which was submitted in his report as chairman of the committee on relations between hospitals, states and cities, Mr. Joseph J. Weber, editor, THE MODERN HOSPITAL, briefly discussed the report. He pointed out the scope and closeness of the relationships that might exist between the states and cities and the private hospitals and also the desirability of determining just what relationships should be established, and said that these relationships should so far as possible be made uniform throughout the states. Furthermore, he urged that the American Hospital Association through the present committee or a similar one should determine more fully what relationships now exist, what relationships would be most desirable and then take whatever steps may be necessary to see that they are definitely established.

Mr. Matthew O. Foley, managing editor, *Hospital Management*, called attention in some detail to a number of the relationships that now exist between state and city departments and private hospitals. Dr. T. K. Gruber, chairman of the section, expressed his belief that most municipal regulations came about because the public had to protect itself against inefficient service on the part of some hospitals and urged the American Hospital Association to continue to take steps to raise the standard of hospital practice, so as to make these regulations increasingly unnecessary.

Dr. Nathaniel W. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., chairman of the intern committee outlined the contents of his report and enumerated the suggested remedies for meeting the problem caused by the shortage of interns: (1) by increasing the length of service in the larger hospitals; (2) by prolonging the residence service; (3) by the use of fourth year students; (4) by using practitioners for postgraduate work; (5) by the use of non-medical aids.

Fifth Year Resident Plan

In discussing this report Dr. Walter H. Conley, medical superintendent, Metropolitan Hospital, Welfare Island, N. Y., after outlining what has happened in recent years in the medical schools and giving some statistics relative to the hospitals that have and do not have interns, offered the suggestion that this problem might be solved to a large extent by employing the men who have had a fifth year as residents for one year with pay. Dr. D. M. Morrill, assistant superintendent, University Hospital, Ann Arbor, Mich., felt that for the training of an intern less than a year is insufficient and that more than a year could be employed with profit. On the whole, however, one year of service in his opinion represented the best method for a basic program for the fifth year internship. Inasmuch as the control of the intern was the most vexing of all problems, he suggested that the American Hospital Association centralize the opinions of the three parties concerned, namely, the hospitals, the medical colleges and the state medical examining boards, and establish a uniform method of control. Dr. Morrill felt that Dr. Conley's suggestion would not meet the problem for the small hospitals, owing to the fact that most of them lack the funds to employ residents. These institutions in his opinion must look to other sources such as specially trained nurses or technicians. The report was also discussed by Dr. Fred C. Zapffe, secretary of the Association of American Medical Colleges, Dr. N. P. Colwell of the American Medical Association, Mr. S. G. Davidson, superintendent, Butterworth Hospital, Grand Rapids, Mich., and Mr. Shroetter, Bethesda Hospital, Cincinnati, Ohio.

The social service section held Thursday afternoon was presided over by Miss Talitha Gerlach, Indiana University, Indianapolis, Ind. The program was opened by Mrs. Gertrude Howe Britton, superintendent, General Free Dispensary, Chicago, Ill., who read a paper on "Practical Social Service," in which she discussed the general plan and policy of carrying out social service in connection with the medical service of a general hospital, rather than the need for and practicability of providing such service about which everyone is agreed.

Social Service and the Hospital

The general plan and policy of carrying out social service in the hospital was discussed by Mrs. Gertrude Howe Britton, superintendent, Central Free Dispensary, Chicago, Ill., in her paper "Practical Social Service."

"According to our present way of thinking, medical social service is an essential part of modern hospital or dispensary service," said Mrs. Britton, "and if this work is to be effective and worth-while, we must plan for the fundamental essentials of central office and field staff."

In speaking of social service in the large city hospital, she said that the solution of the difficulties incident to the management of the necessary field service for the social service department of a hospital or dispensary operating in a large city is through cooperation. For any hospital to assume the responsibility of re-investigating home conditions which are already known, is not only expensive, but is a useless duplication which does not in any way help solve the problems of the community: a properly thought out plan of cooperation is the fundamental essential of carrying out a social service program in any large community in which different agencies are operating.

The medical social service worker, she said, should be closely associated with the actual medical work of a clinic, she should be close enough to the medical staff to correctly understand and interpret the things to be accomplished as indicated by the doctor in any given case, should know the medical diagnosis and plan the essentials of treatment.

Mrs. Britton concluded by saying that in all cases the service must be worth the cost and that duplication of effort must be avoided by cooperation and coordination.

Features of Social Service Explained

Miss M. Antoinette Cannon, president, American Association of Social Workers, New York, N. Y., followed with a paper on "The History and Development of Hospital Social Service." Miss Cannon briefly reviewed the early history of the social service movement which started about twenty years ago, and mentioned four elements in the hospital situation of that time which stimulated the response now called social work: (1) the resourcelessness of the sick, (2) the poor response to treatment on account of conditions not under medical control, (3) preventable sickness, and unnecessary recurrence of sickness, (4) the use for teaching purposes of patients, apart from their homes, in wards and clinics limited the opportunity of the medical student to learn the significance of immediate environment in relation to sickness and to treatment. The question of

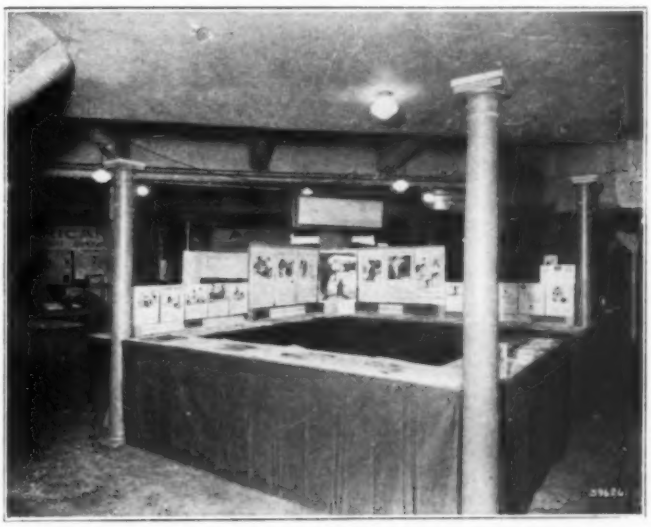
the prevention of sickness which was related to bad environment presented itself to leading physicians in Boston, and thus came to be established, Miss Cannon said, the social service department at the Massachusetts General Hospital.

A Part of the Hospital System

Some definite tendencies are apparent in the organization of social work in hospitals which, the speaker said, was originally a volunteer service but has now become part of the hospital system proper although, in some instances, salaries are still supplemented by auxiliary committees. Since the early beginnings of social service work, departments have been established in more than 400 hospitals in the United States and Canada. A large department, Miss Cannon stated, costs from $30,000 to $40,000 yearly to maintain. The cost, however, may be as low as $2,000 per year. She mentioned three other developments, namely, management of patients, teaching of pupil nurses, and research, and referred to another aspect of the work which is in the nature of a social or industrial survey.

Psychiatric Social Service

"The Development of Psychiatric Social Service," was the title of the next paper given by Miss June Frances Lyday, chief of social service, Psychopathic Hospital, University of Iowa, Iowa City, Ia. Miss Lyday said that in 1922 the American Association of Hospital Social Workers sanctioned the establishment of a section on psychiatric social work within its ranks, and it is estimated that there must now be nearly 200 qualified psychiatric social workers throughout the country. The demand for well trained psychiatric workers is much greater than the supply and the development of this service has taken place almost entirely in the last ten years. Miss Lyday pointed out that the fields for the psychiatric social worker are manifold. She has a place in the work of the juvenile courts which are making use of psychological clinics for child study; she is coming more and more into contact with school children; the girl scout movement makes use of her services; her work can find many applications in the development of mental hygiene in industry, and another of her duties is to contribute to medical social research and make studies of social problems connected with mental disease.



The exhibit of the National Child Welfare Association was filled with literature of various descriptions which is helping to produce healthier children.

Problems which are peculiar to the small hospital were featured at the small hospital section Thursday afternoon.

Discuss Needs of Small Hospital

In her paper on "Needs of the Small Hospital," Miss Mary E. Gladwin, nurses' board, St. Paul, Minn., told of the difficulties which are peculiar to the small hospital. The majority of small hospitals, she pointed out, are handicapped by the lack of sufficient funds to make them as efficient and serviceable as they could be to the community. Because of this, boards of trustees select superintendents who, they think, will be of the greatest economic advantage because they will work for a small salary. In the end, Miss Gladwin pointed out, such officials are an extravagant expense to the institution because they are generally insufficiently trained or lack proper qualifications for such a position.

In addition to the difficulty of maintaining a competent superintendent, Miss Gladwin said that the problem of nursing schools was a vital one for the small hospital. There again, the institution endeavors to economize by detailing a maximum amount of menial tasks to the student nurse, thereby depriving her of the intellectual training which would fit her later to become a supervisor of nurses or a hospital superintendent.

Advocates National Inspection

Miss Gladwin advocated a national system of inspection for small hospitals similar to that which is being undertaken by the American College of Surgeons by which some system of standardization of nursing schools might be brought about for the benefit of small hospitals. She also drew attention to the benefits which might accrue from consolidation of small hospitals in the manner which rural schools have been brought together the past few years. Such a system, Miss Gladwin believes, would bring about a better and bigger laboratory service, and make the small hospital a greater teaching center.

In the discussion which followed the paper the question of the advisability of a regular staff for the small hospital and what can be done in the way of securing graduate nurses were taken up by representatives of small hospitals from different sections of the country. The general opinion expressed was that the small hospital should have a regular, but closed staff.

In the absence of Miss Minnie Goodnow, R.N., superintendent, Children's Hospital, Washington, D. C., Miss Mae Fye, Mercy Hospital, Benton Harbor, Mich., read the paper.

"A patient has a right to expect three things of the hospital," said Miss Minnie Goodnow, superintendent, Children's Hospital, Washington, D. C., in discussing "What Constitutes Good Service to the Patients" in her paper on that subject.

Good Service to Patients

"A patient has a right to demand safety, comfort and a certain amount of consideration." These things she brought out, will bring the management of a hospital to resemble that of a hotel.

Miss Goodnow emphasized that these demands included adequate buildings having sufficient fire protection, competent physicians and personnel, pleasant rooms, good food properly served, freedom from noise, and courtesy from executives and employees.

From the patient's viewpoint, Miss Goodnow said that there were five criticisms very generally made of the ordinary hospital, namely: the food is not satisfactory; the

hospital is noisy; the patient's calls are not promptly answered; the patient is wakened unduly early in the morning for his toilet; and too many nurses are caring for him.

After discussing these points in detail and suggesting remedies in individual cases, Miss Goodnow concluded by pointing out that the criticisms of the hospital are largely a matter of psychology, and that the intangible something called atmosphere is often the thing upon which success or failure depends more than upon equipment or number of personnel. "The superintendent who can create and maintain in his hospital a feeling of friendliness," said Miss Goodnow, "is going to find his hospital popular."

She concluded that the attitude should be developed that the patient is a guest of the hospital and that the viewpoint of the salesman might be well adapted that "the customer is always right," "Study the patient's psychology," she said, "and treat him as a guest."

In discussing the paper, Miss Marietta Barnaby, superintendent, Henry Heywood Memorial Hospital, Gardner, Mass., said that one of the most justifiable complaints of the patients was that too many nurses are caring for them and urged that the small hospital should try to produce a more hospitable atmosphere through its personnel.

The paper on "Community Work for Small Hospitals" was read by Miss Washburn, Lawrence, Mass., in the absence of Miss Mary A. Baker, superintendent, Henry W. Putnam Hospital, Bennington, Vermont.

Small Hospital as Health Center

In the discussion which followed the paper, the need for the small hospital developing into a health center and dispensary was brought out and greater publicity was advocated by means of exhibits in county fairs, and cooperation with the movement of National Hospital Day.

The program was closed by a talk on her experiences in visiting hospitals abroad, by Miss Margaret Cumming, superintendent, The Christian H. Buhl Hospital, Sharon, Penn.

Miss Cumming visited many hospitals of Japan, the Philippines, India, Egypt, and other oriental countries and gave in brief her impressions of hospitals in those countries, all of which, she claimed, suffer by comparison with the modern development of hospitals in this country. She pointed out the need which many of those hospitals have for combating such problems as leprosy and poisonous bites, and other diseases which are peculiarly foreign to us.

"What the Hospital Can Do for the Prevention and Relief of Heart Disease," by Dr. James B. Herrick, president, Chicago Association for the Prevention and Relief of Heart Disease, Chicago, Ill., was the opening paper of Friday evening's general session.

Prevention of Heart Disease

In his paper on "What the Hospital Can Do for the Prevention and Relief of Heart Disease," Dr. James B. Herrick, president, Chicago Association for Prevention and Relief of Heart Disease, Chicago, Ill., enumerated the services which the hospital can perform in diseases that are part to result in heart disease as well as cases of cardiac breakdown.

Dr. Herrick said that the hospital can treat in the best possible way diseases that are apt to cause heart disease, such as rheumatism, chorea, and syphilis by proper treatment by surgical or other means of foci of infection, such as diseased tonsils. "This does not, however, mean the indiscriminate removal of tonsils," said Dr. Herrick.

In chronic cases of inflammation of the heart, Dr. Herrick pointed out that the hospital can be lenient in turning out these patients. In a cardiac breakdown the hospital has an important function in securing rest for the patient in providing proper medical treatment. He also believes that the hospital can do a great deal through its social service department in the way of seeing that its home conditions are such that the patient can and will continue the rest there and the proper use of medicine. In many instances this implies a re-adjustment of employment conditions, the fitting of the occupation to the patient's ability to work.

Wards as Teaching Centers

He also believes that the hospital can do a definite piece of work in cooperating with such organizations as the Society for Prevention and Relief of Heart Disease in its aim to secure beds for chronic cardiacs who are hopelessly ill, for chronic cardiacs who need long periods of rest and for cardiacs who are convalescent from breakdowns or acute illness.

Further, he pointed out that the hospital can aid in furthering research in its wards, its clinics, and in its laboratories and can help in the education of doctors and nurses by utilizing its wards in the way of teaching.

This was followed by a paper on "Religion in the Hospital," by Rev. Wilson E. Donaldson, chaplain, Cook County Hospital, Chicago, Ill.

The Chaplain's Place in the Hospital

Mr. Donaldson said that his eight years of experience in one of the largest hospitals of the country had convinced him that religion should have a definite place in the conduct of every hospital for the hospital can and does perpetuate the work of Christ.

He pointed out the definite work which the chaplain may do in bringing about a healthy mental state which is a necessary requisite to physical improvement.

"Every institution," he said, "would increase its efficiency by making definite provision for the presence of one or more religious leaders in the institution whose visitation of the sick at the bedside, or whose conduct of chapel services would give a religious tone and divert the thought of the patients from themselves of their particular ailment."

Should Cooperate with Superintendent

Mr. Donaldson showed by example how the chaplain can be of direct help to the superintendent in reporting the suggestions of patients who are wont to tell their complaints, preferably to the chaplain. The chaplain can thus cooperate with the superintendent in improving the service of the hospital in addition to his work as spiritual advisor in visiting the patients, performing marriage ceremonies, baptismal services and other spiritual needs of the patient.

The chaplain is also in a position to know the detailed needs of the patient in the way of reading matter and can help in attending to these comforts of the patient. He can give assistance to the patients in writing to his family or in other letters which the patient would neglect, were it not for the interest of the chaplain. There are countless services which, if the chaplain performs tactfully, he can be of direct benefit not alone to

the patient, but to the hospital. He therefore believes that it is the part of wisdom for every hospital to make provision for religious influence and instruction for those who are being cared for in the institution.

The Rev. E. N. Ware, chaplain, Presbyterian Hospital, Chicago, Ill., in discussing Mr. Donaldson's paper said that most hospitals had come into being through the direct influence of the church and that the church ought to be represented somewhere along the line of the hospital's activities.

Another section of the model kitchen showing the bakeshop and various electrical equipment such as dishwashers and vegetable devices opposite.

Dr. Frederick B. Morehead, dean, dental department, Illinois University, Chicago, Ill., spoke on "Hospital Dentistry." Before coming to his main topic, Dr. Morehead entered a vigorous protest against too much routine in the work of the hospital. "Through routine," he said, "we lose freshness in our work and lose the proper value of our function; routine is the curse of the nurse, the doctor and the intern; the most vital thing is to keep truly alive and to avoid ruts."

Mouth Neglected in Medical Education

Dr. Morehead stated that medical education has never paid any attention to the mouth. The curriculum of the medical student has nothing on it; medical literature has nothing to say about the mouth, and therefore the dental college was organized. "The medical student," said Dr. Morehead, "looks upon the mouth as belonging to the dentist, while the dentist does not, and cannot, because of his training, orient the mouth in relation to the individual. He thinks in terms of teeth and not in terms of the composite whole or in terms of physical well-being."

The solution, according to Dr. Morehead, is to have the dentist educated as a medical specialist, for teeth decay is the most wide-spread of all diseases and the dentist must understand the effect of infections which characterize the mouth, in their relation to the body; he must not think of a tooth but of the function of that organ in its natural relation to life.

Dr. Morehead feels that the hospital has a function in relation to the mouth, but the hospital cannot practice dentistry, as it is not its job. Its function is rather to have thoroughly and carefully examined the mouth of every individual who enters the institution. The hospital should undertake to advise the individual exactly what should be done to put his mouth in a condition of safety. There the function of the hospital ends, he believes.

Tuberculosis in General Hospitals

Dr. Myron W. Snell, supervisor, Tuberculosis Sanitarium, National Home for Disabled Volunteer Soldiers, Milwaukee, Wis., next read a paper on "Care of Tuberculous Patients in General Hospitals," in which he presented the subject both from the viewpoint of the patient and that of the public.

From the viewpoint of the public, he said that hospitals were expected to have facilities for the care of tuberculous patients and that these patients should not be placed in anything but private rooms. In denouncing the ward system, he said, "It is hoped that some day the power which builds hospitals will find it possible to do away with the ward idea in hospital construction." But for the time being, he advocated the cubicle system in wards which makes the patient within just as safe as in a private room.

He drew attention to the fact that the recommendation of the trustees of the American Hospital Association was lacking in the word "treatment" which was an important point, for if general hospitals are to admit cases of tuberculosis, he said, they must of necessity provide for proper treatment in this class of disease. He said that with the modern methods of diagnosis it was an obligation for hospitals wherever located to provide adequate treatment for this disease.

Develops Educated Personnel

"Probably the greatest good to come from the hospitalization of tuberculosis, in the general hospital," said Mr. Snell, "will be accomplished in having an educated personnel for the proper care and treatment of the disease. The acute miliary case, the hemorrhagic case, and the terminal case should not be transported for a great distance to a sanatorium but should receive treatment in the general hospital."

Dr. Snell's paper was briefly discussed by Major B. E. Hedding, chief of tuberculosis service of the same institution.

Pediatrics and the Hospital

"The Children's Department of the Hospital," was the subject of the next paper, by Dr. H. M. Helmholz, Mayo Clinic, Rochester, Minn. Dr. Helmholz said that the development of pediatrics in the last twenty-five years had completely changed the relationship of the children's department in the hospital to the other departments. Children used to be treated as small adults; they were taken care of by the internist. "Now in the city of Chicago alone," he said, "there are over fifty men who are practising exclusively among children." Dr. Helmholz feels that every child should be considered first of all from the point of view of its general health and should be examined by a pediatrician, as a matter of routine, on its admission to the hospital. "Children," he stated, "should be admitted always on the children's service and on the surgical service, and it will be found that the surgeon, the orthopedist, the nose and throat specialist will act as consultants and act in cooperation with the pediatrist who should have the power to select sufficient assistants to carry on the work in his department." In conclusion, Dr. Helmholz said that the interest of the community in a hospital can be stimulated more readily by the work done in the children's department than in any other way.

The general session Friday morning was opened by a

paper by Sister Rose Alexius, superintendent, Good Samaritan Hospital, Cincinnati, Ohio, on the subject "The Heart of the Hospital." Sister Alexius dwelt on the fact that the whole plan of the hospital work should be in harmony with the spirit of Christ and that this spirit should be the heart of the hospital. Much care and prudence, Sister Alexius said, must be exercised in choosing those who are to work in hospitals. The work is a round of exactions and duties and requires not only the physical presence and exertion of the worker but demands that he be unsparing of self; in addition to skilled knowledge and expert training he must have a special aptitude for the work.

The Intern Problem

"The one and only legitimate purpose of the hospital internship is educational," said Dr. N. P. Colwell, secretary of the council on medical education and hospitals, American Medical Association, Chicago, Ill., in his paper "The Intern Problem from the Standpoint of Medical Education."

Dr. Colwell said that if this purpose is not fully recognized and carried out the internship is a counterfeit and an actual menace to the patient. He said that through well conducted intern training, the hospital is pervaded by an educational, or research atmosphere which keeps it active, progressive, and up-to-date.

He traced the development of the intern problem from the educational standpoint showing that at first hospitals were indifferent to the intern problem and that today the services of the intern are of great value to the hospital. He presented figures to show that the educational standards which have been set for hospitals which are approved for internships have reduced the number which are qualified to train interns. "The problem, today," he said, "is reversed, and all one hears is of a lack of graduates to fill the places in the hospital."

Dr. Colwell Suggests Longer Internship

Dr. Colwell believes that an aid in solving the problem of intern supply would be to lengthen the intern service to eighteen or twenty-four months. He said that in some of the larger hospitals the interns are already prolonging their service voluntarily. Another thing which he believes will relieve the situation will be the extension of intern training to provide graduate medical instruction for resident physicians and others. This would be of special advantage, he claims, in special hospitals such as those for diseases of the eye, ear, nose and throat, or other clinical specialties.

In speaking of the hospital as an educational center, Dr. Colwell said: "It may be safely predicted that, as time goes on, hospitals will be considered less and less progressive or safe institutions in which to treat the sick unless they are also distinctly educational institutions. "He expressed the hope for hospitals to become educational centers where physicians of the community or county may meet for clinical conference or special clinics.

Dr. Colwell closed by enumerating the desirable conditions for the training of interns. First of all, the hospital should be large enough to provide a fairly large supply of patients both acute and chronic, and a rotating service in which the intern will render services in medicine surgery, and obstetrics. (2) The hospital should be liberally equipped with a servicable laboratory and a satisfactory x-ray laboratory with expert supervisors in charge. (3) Most of all the hospitals should have an attending staff of physicians who are individually interested in the education and welfare of the interns and prevent their time being wasted in duties belonging more to orderlies and nurses.

Dr. C. Henry Davis, Milwaukee, Wis., next gave a paper on "Nitrous Oxide Gas in Obstetrics."

Nitrous Oxid-Oxygen in Obstetrics

In discussing the use of nitrous oxid-oxygen in obstetrics, in his paper on "Nitrous Oxid-oxygen in Hospital Obstetrics," Dr. C. Henry Davis, Milwaukee, Wis., pointed out the early objections to the use of anesthesia on the grounds that it was harmful in its immediate and after effects, and how the fears which attended its administration formerly had been overcome by its overwhelming success in the past few years.

"Today," said Dr. Davis, "there exists no controversy as to the desirability of relieving labor pains; it is just a matter of learning the use of the most effective and least harmful analgesic. Nitrous oxid is generally recognized as the most satisfactory obstetrical analgesic. It is the one anesthetic, thoroughly tested, which will relieve the severe pain of labor without, at the same time, diminishing the strength and frequency of the contractions."

Dr. Davis said that the real problem connected with analgesia is that of administering it, especially the financing angle of its use. For economical use he advocated a large machine with some sort of reducing valve and automatic regulators. By purchasing the gas in large cylinders the cost is lowered, provided that leaks are prevented. He said also the the cost of the gas should not exceed five dollars.

He told of his personal experience in employing anesthetists and pointed out that interns and nurses, in many instances, could very ably administer the nitrous oxid gas thereby keeping the costs within the reach of the average patient. The technic, he says, is not difficult and may be mastered within a short time by anyone who will study the problem.

Dr. Davis concluded by giving some data as conclusive evidence of the successful use of nitrous oxid-oxygen through the lessening of the mortality rate and the decrease of infection and pathological conditions which were formerly so common in the absence of the use of analgesics in obstetrics.

Departments of Physiotherapy Urged

The final paper of this session was on "Should General Hospitals Establish Departments of Physiotherapy?" This paper is printed in full on page 512 of this issue.

The business session Friday afternoon was taken up with final reports and announcements of committee appointments. The election of officers resulted in the following: president-elect, E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill.; first vice-president, J. B. Franklin, superintendent, Baylor Hospital, Baylor, Texas; second vice-president, C. W. Munger, M.D., Blodgett Memorial Hospital, Grand Rapids, Mich.; third vice-president, Miss Emily F. Loveridge, superintendent, Good Samaritan Hospital, Portland, Ore.; treasurer, Asa S. Bacon, superintendent, Presbyterian Hospital, Chicago, Ill.; trustees, A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Que.; and Miss Alice Thatcher, superintendent, Christ Hospital, Cincinnati, Ohio.

The report of the committee on resolutions was read by Chairman Richard P. Borden, who introduced two

resolutions unanimously adopted by the assembly. The first resolution had to do with the present status of the nursing profession. The association went on record as urging that nurses properly registered as such shall be included as professional, and protested against any rules or classification which will place these nurses in a lower status than that already recognized by law.

The second resolution passed was an endorsement of National Hospital Day to be annually observed on May 12 of each year.

The report of the committee on constitution and rules was also read by Mr. Borden. The membership amendment presented at the Wednesday morning's session was unanimously adopted by the assembly. By this amendment any person or organization not residing on the continent may become a subscribing member of the association upon complying with the rules as set forth in the constitution.

The report of the special committee to draft resolutions was given by Dr. E. T. Olsen, chairman, who introduced two resolutions unanimously adopted by the assembly.

The two resolutions adopted were that expressions of sincere sorrow be extended by the association to the wife of the late Dr. Arthur B. Ancker and to the family of the late Dr. Herbert Burr Howard, both of whom were past presidents and faithful members of the association.

A gavel presented to the association by Mr. Asa S. Bacon, outgoing president, was handed by him to the new president, Dr. M. T. MacEachern who took the chair. After expressing his appreciation in a few brief remarks, Dr. MacEachern introduced the newly-elected officers and appointed the following committees:

Constitution and rules—Chairman, Richard P. Borden, trustee, Union Hospital, Fall River, Mass.; the Rev. H. L. Fritchel, superintendent, Milwaukee Hospital, Milwaukee, Wis.; and George T. O'Hanlon, M.D., superintendent, Bellevue and Allied Hospitals, New York, N. Y.

Miss Marion Peterson, dietitian, Lakeside Hospital, Cleveland (left) with two friends, Miss Margaret Hoffmann and Miss Alice Ferguson.

Resolution—Chairman, W. H. Conley, M.D., medical superintendent, Metropolitan Hospital, Welfare Island, N. Y.; John Peters, M.D., superintendent, Rhode Island Hospital, Providence, R. I.; and H. K. Thurston, business manager, Madison General Hospital, Madison, Wis.

Membership—Chairman, Louis A. Sexton, M.D., superintendent, Hartford Hospital, Hartford, Conn.; Elmer Matthews, M.D., superintendent Wilkes-Barre Hospital, Wilkes-Barre, Pa.; Miss Marietta Barnaby, Henry Heywood Memorial Hospital, Gardner, Mass.

Out-patient section—Chairman, Alec N. Thomson, M.D., medical secretary, committee on dispensary development, New York, N. Y.; A. K. Haywood, M.D., superintendent, Montreal General Hospital, Montreal, Que.; and Walter Niles, M.D., dean, Cornell University Medical College, New York, N. Y.

Legislative committee—Chairman, E. T. Olsen, M.D., superintendent, Englewood Hospital, Chicago, Ill.; Howell Wright, Cleveland Hospital Council, Cleveland, Ohio; and F. O. Bates, superintendent, Roper Hospital, Charleston, S. C.

Nomination—Chairman, C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash.; Walker White, superintendent, Wesley Memorial Hospital, Atlanta, Ga.; E. G. Flaws, superintendent, Wellesley Hospital, Toronto, Ont.; Miss G. Borland, superintendent, Deaconess Hospital, Green Bay, Wis.; and George B. Landers, M.D., superintendent, Highland Hospital, Rochester, N. Y.

The concluding session of the conference on Friday evening consisted of an open forum and banquet presided over by Dr. M. T. MacEachern, the new president. Prior to sitting down to dinner the delegates were entertained in the east foyer of the auditorium by a small orchestra who later accompanied a number of well known songs taken part in by the diners under the leadership of Mr. Robert Jolly, superintendent, Baptist Hospital, Houston, Texas. After approximately three hundred delegates, guests and exhibitors had taken their seats Dr. MacEachern, wielding the new gavel presented to the association by the retiring president, called upon Mr. Bason to make a few brief remarks as the retiring president. Mr. Bacon was followed by Dr. A. R. Warner, executive secretary of the association, Mr. Albert C. Meyer, Mr. E. S. Gilmore, Mr. Robert Jolly, Dr. I. Clark Gary, Rev. H. L. Fritchel and others.

A number of helpful suggestions were brought out in the open forum for improving the work and standing of the association. Among them were these: an active campaign to increase the association's membership; an experiment with a field worker; efforts to win a wider cooperation from trustees; fewer formal papers at the conference; more time for studying exhibits and holding the banquet earlier in the conference. Persuasive appeals were made by representatives from Los Angeles and Washington that the next annual conference be held in those cities. The forum concluded with a brief address by Dr. MacEachern, summarizing the important accomplishments of the conference as a basis for future progress. Following the forum those in attendance adjourned to an informal dance in Juneau Hall.

SERVICE BUREAU PROVES POPULAR

One of the busiest booths of exhibitors at the A. H. A. conference was that of the Hospital Library and Service Bureau which was crowded from morning until night with persons eager to obtain information on building plans and details of construction as well as package libraries and literature on all phases of hospital work. The exhibit featured 600 floor plans which form a part of the permanent exhibit at the headquarters of the bureau throughout the year.

SOCIAL ASPECTS OF THE CONFERENCE

The Silver Jubilee Convention of the American Hospital Association was not without its social functions which added much to the enjoyment of those in attendance. Through the generous and untiring efforts of the social committee under the chairmanship of the Rev. H. L. Fritchel, many entertainments were arranged for delegates.

Six leading clubs of Milwaukee, the Athletic Club, the City Club, the Milwaukee Club, the Nurses' Club, The Town Club, and The Women's Club of Wisconsin extended the courtesies of their houses and club privileges to those attending the conference.

Open house was held for all delegates and guests of the convention on Tuesday noon by the Ladies' Auxiliary of Mt. Sinai Hospital. The hospital also served luncheon to the delegates.

Wives of superintendents were entertained by the board of the Milwaukee Infants' Hospital, Wednesday afternoon. After an automobile tour of the city a reception was held for the guests at the home of Mrs. Charles Ott.

Through the courtesy of the Milwaukee Rotary Club a sightseeing trip was enjoyed by the delegates and guests Wednesday noon. At one o'clock, Fifth Street in front of the auditorium was lined with automobiles which were soon filled with enthusiastic visitors.

Miss Rena S. Eckman, who was re-elected president of the Hospital Dietetic Council, with Miss E. M. Geraghty.

The Wisconsin Nurses' Club entertained members of the association at a tea Wednesday afternoon from 4 to 6 o'clock at their new club house.

On Thursday from 4 to 6 o'clock the board of the Milwaukee Children's Hospital gave a tea for women members and guests at their nurses' home.

Entertainment was also furnished by the organ preludes which preceded many of the sessions held in Plankinton Hall.

The convention closed Friday evening with a banquet and dance held in Market Hall which was made possible by the work of the local committee.

INTEREST GROWS IN DISPENSARIES

Keen interest in dispensaries was evidenced by the large crowds who visited the out-patient committee's booth at the A. H. A. exhibit. The charts showed the various phases of dispensary development and the extensive growth of out-patient work in small communities as well as in the larger cities of the country.

One set of charts showed the number of dispensaries that are charging fees both for admission and for treatment. Another showed the value of follow-up work and others, the methods of evaluating the dispensary work and the appointment system. The twelve steps in getting the patient from the dispensary entrance to the clinic were also outlined.

A. L. A. HAS ATTRACTIVE EXHIBIT

One of the interesting non-commercial exhibits at the recent conference of the American Hospital Association was that of the American Library Association. Here were scores of attractive posters used for publicity work by a number of the public libraries that have now established hospital library service. The exhibit included one of the standard library book carts of the American Library Association, filled with a selection of books and magazines suitable for patients. There were also books on occupational therapy, copies of a new book on "The Hospital Library" by Edith Kathleen Jones, and other literature of interest to hospital library workers.

DEMONSTRATE INSULIN

Universal interest was displayed in the insulin demonstrations which were held at the booth of the Royal Victoria Hospital, Montreal, at the A. H. A. exhibition. Two nurses from that hospital were kept busy answering the questions concerning the treatment of diabetes mellitus and the administration of insulin. Several demonstrations by doctors from that hospital were given of the scheme of treatment of the diabetic patient from the admission to the hospital until discharge. The course of treatment as followed out in the Montreal hospital will be outlined in a succeeding issue of the magazine.

MODEL CARDIAC CLINIC DEMONSTRATED

An exhibit of a model cardiac clinic and of heart disease as a social problem was shown at the booths of the Association for the Prevention and Relief of Heart Disease, New York, N. Y., in cooperation with the out-patient committee of the American Hospital Association at the Milwaukee conference. Miss M. L. Woughter, executive secretary of the former association gave a demonstration clinic Wednesday, Thursday and Friday of the convention. Each morning conferences were held with visitors concerning the starting of new clinics convalescent homes and vocational guidance, and consultation was offered concerning the work which is being done in Chicago.

EPISCOPAL HOSPITAL WORKERS MEET

The Episcopal hospital workers held a meeting Wednesday evening October 31 in conjunction with the A. H. A. meeting at the Republican Hotel, Milwaukee, at 6 p. m. The meeting was held under the auspices of the National Department of Christian Social Service and was presided over by Dr. William S. Keeler, Cincinnati, Ohio.

The program was as follows: "Our Hopes and Plans for Church Hospitals," by the Rev. Thomas A. Hyde, superintendent, Christ Hospital, Jersey City, N. J., "Nursing as a Church Woman's Opportunity," by Miss Edna L. Foley, superintendent, Visiting Nurse Association, Chicago, Ill., "What is Hospital Social Service," by Miss Amy F. Cleaver, chief of social service, St. Luke's Hospital, New York, N. Y.

SOCIAL WORKERS DEVOTE CONFERENCE TO ROUND TABLE DISCUSSIONS

THE SEMI-ANNUAL meeting of the American Association of Hospital Social Workers, which was held in Milwaukee, from Oct. 31 to Nov 2, was well attended. The committee of which Miss Talitha Gerlach of the University of Indiana was chairman, planned, in addition to the program of the social service section of the American Hospital Association, an opportunity for the social workers to discuss intimately some of their most outstanding problems, through a series of well-planned round tables.

Those participating in the round table on "Evaluation" which was led by Miss Ida M. Cannon, Massachusetts General Hospital, Boston, Mass., agreed that the social service department should keep clearly in mind the purpose for which the medical institution of which it is a part really exists and from time to time consider the contribution that has been given to that purpose. social service department should also in its social case work consider more definitely what is the aim in each case and work out some test of that aim. The registering of a tentative plan in the beginning of a record may help in the check up and also in the test of whether intelligent changes in plan have been made, on the basis of deeper knowledge of the patient's need. It was suggested that an outline of job analysis printed in the bulletin would be helpful to those who have not done such job analyses. It was recommended that a clear statement of what should go in a policy book, and of how to keep it up to date might well be printed in the bulletin and a statement formulated giving a six months' plan.

Miss Cornelia D. Hopkins of the Institute of Juvenile Research, Chicago, Ill., led the round table on "The Scope of Cases Handled by Psychiatric Social Workers in Relation to General Case Work Agencies." Discussion hinged on the following questions: Which types of cases can be turned back to the referring agency for social supervision, and which types should remain with the psychiatric case work agency for treatment? On what basis can these types be defined? Reports were received from the agencies represented as to the basis of their selection of cases. The following groups were considered: (1) Community psychiatric problems which come to the attention of the psychiatric social worker before coming to the mental health clinic. (2) Paroled patients. (3) Treatment cases. (4) Cases in which the psychiatric social worker acts in an advisory capacity.

Miss Lean R. Waters, director of social service, Johns Hopkins Hospital, Baltimore, Md., secretary of the American Association of Hospital Social Workers.

Psychiatric Training Needed

It was generally agreed that one type of case which might properly be handled by the general case work agencies was that in which the diagnosis was feeblemindedness. Since psychiatric workers could not hope to cover all psychiatric problems in any community, one of her functions must be the stimulation of psychiatric training for all general workers.

Mrs. Mary D. Ballou, National Military Sanitarium, Marion, Ind., led the discussion on "Venereal Disease Problems." Various methods were discussed as to the means through which social workers can be of the greatest assistance in the treatment of these problems, with the general agreement that the cases needed individual study and social treatment by well trained and tactful social workers. Persuasion was advisable for cases needing continual treatment and for examination of others exposed to the disease, but in cases of especially uncooperative patients, who are a menace to the community, the authorities should be notified and efforts made to force treatment.

Phases of Children's Work

Miss Edith I. Epler, of the Michael Reese Dispensary, Chicago, Ill., presided at the round table on "Children's Work". Some of the phases of children's work which were discussed were the advisability of an interview with the patient and parents by the social worker before the patient is seen by the physician; the importance of educational work and entertainment with the patient and the parents while waiting in the clinic for examination; the value of occupational and educational work for ward patients through special teacher, students and volunteers; the participation of social workers in health classes, such as thyroid and cardiac. The discussion resulted in the general agreement that the duty of the social worker besides interpreting to the physician the patient's surroundings and personality and to the patient and his family, the recommendation of the doctor should be largely educational to parents and patient as a means of preventing future illness.

The round table on "Community Relationships," which was led by Mrs. Webb, Lakeside Hospital, Cleveland, Ohio, brought out several definite points.

It was agreed that hospital social workers should not take too much medical knowledge for granted in discussing medical social problems with lay social workers but should realize that they have an unique opportunity to interpret health to the community in lay terms.

They should consider it an opportunity and a responsibility to organize series of medical lectures by the doctors on their staff for the benefit of outside social workers.

They should have definite hours when they can be seen personally by representatives of other agencies and all the agencies should be kept informed of the hours of clinics and office hours of the workers. It was felt that the ideal reporting system need be a combination of a written report and a personal interview whenever possible; also that in the personal interviews the full-

est explanation be made of the medical situation realizing that the less experienced the outside worker, the more explicit and thorough the explanation should be. The question of securing the consent of the patient before giving out medical information on his case was discussed, but no unanimity of opinion arrived at. The trend of thought seemed to be toward adjusting the policy in the light of the laws of our respective states.

Social Service and the Nurse

Mr. Robert E. Neff, superintendent, Robert Long Hospital, Indianapolis, Ind., led an active discussion on "Social Service Training for Pupil Nurses and Medical Students." The importance of establishing a close working relationship between physician, nurse, and social worker and patient was brought out. Every social service department should be a teaching department as well as one concerned with the social welfare of the patient. Lectures on social service should be organized for the students in the medical schools and in the training schools for nurses. A recommendation was made that the American Association of Hospital Social Workers appoint a committee to study the courses which are being given and to act as advisers to those charged with teaching medical students and nurses.

Miss Gertrude Scott, Essex County Juvenile Clinic, N. J., led the discussion on "Underlying Principles of psychiatric Social Work." Some of the topics covered in the discussion were:

(1) a development of psychiatric social service; (2) factors involved in adjusting the individual to his environment; (3) sphere of the psychiatric social worker in adjustments; (a) changing attitude of community; (b) adjustment through employment; (c) adjustment through school work with individual teachers—value of open clinics and classes for teachers; (4) educating attitude of the courts, in juvenile courts, in the adult courts.

Increasing interest in the question of admissions was shown in the round table led by Miss Alma Holzshuh, Minneapolis General Hospital. As the appreciation on the part of the general public of the value of dispensaries and hospitals grows, the question of dispensary abuse looms up more prominently—making more necessary some well thought out admission system. Shall the admitting officer be a social worker—or a financial investigator? Can a uniform standard, a budget scale be used which will help guide the decision in admitting problems? What about the admission and social treatment of non-resident cases, the homeless man, etc. Who is responsible for the patient refused admission? For what length of time shall a free pass be granted and how often should the case be reinvestigated? What should be included in the admission interview? These and other questions were brought out as day by day problems which are being presented to social service departments.

Encourage Volunteer Service

One of the most interesting groups was that on "The Use of Volunteers" with Miss Janet Schoenfeld, Michael Reese Dispensary, Chicago, Ill., as leader. The four points brought up in the discussion were: (1) How can social work justify allowing volunteer service in the professional field when in no other field is such endeavor allowed? (2) Should volunteer service be supervised by a social worker even though work done is not undertaken by the social service department? (3) Should there be competition allowed between paid and unpaid service? (4) If in two months the Red Cross (after the Armistice) dropped from 1,000 to 0, what can be done to re-awaken the volunteer to service in civilian life?

It was agreed that no supervisor should accept a volunteer without (a) knowing the job and knowing the volunteer, (b) creating jobs for volunteers where none already existed should be discouraged. When a volunteer in any way interferes with the service for which the social service department was organized (even though her social position in the community would make her an asset), this interference makes her a liability.

Proper chosen, properly trained, properly supervised volunteers are invaluable and their service shall be encouraged.

BOOTH DISPLAYS ACHIEVEMENTS OF SOCIAL WORKERS

The booth of the American Association of Hospital Social Workers proved throughout the A. H. A. Convention to be most profitable as a center for those wishing to form valuable professional friendships, and as a bureau of information on development of standards for hospital social work.

The booth contained educational material showing the results of social research and individual social case work, these materials being furnished by workers representing various departments from all over the United States. Case studies and statistical charts were furnished by the departments of social work in the following outstanding hospitals and institutions: Massachusetts General Hospital, Boston Dispensary, Bellevue Hospital, Stanford University Hospital, New Haven Hospital and Dispensary, Eastern State Hospital for the Insane, Lakeside Hospital, Johns Hopkins Hospital, Michael Reese Dispensary, Indiana University Hospital (Robt. W. Long) and Milwaukee Children's Hospital.

Statistical maps in the booth have attracted much attention. A map of the United States indicated by small colored incandescent lights the organized district associations of hospital social workers in the Middle-Atlantic district, the national headquarters at Baltimore, Md., being represented on the map by a bright red light, the district organizations by pale green ones.

The Illinois District of Hospital Social Workers displayed a statistical map showing the distribution of cardiac cases which have been followed socially from the various clinics and hospitals of that district. Michael Reese Dispensary is represented by statistical charts tabulating certain social and psychological aspects of cases treated medically and socially in the institution.

Indiana University Hospital social service department submitted a map showing the remarkable growth of work carried on by the state hospital through the state worker, Miss Gerlach, who visits communities represented in the hospital by indigent patients, discovering possible social resources in these communities and stimulating them to greater activity in the care of the sick and the socially inadequate of their respective localities. The map on display in the booth represents by dots the towns, villages and even secluded country districts visited by Miss Gerlach or the other state workers since 1915.

Not the least frequent among requests for service at this booth were those made by superintendents of hospitals where social service departments are to be installed in the near future. It was evidenced at the booth that the association is materialy aiding in the large aim of the advancement of the cause of medicine and of making the hospital a powerful social agency in its community.

OCCUPATIONAL THERAPISTS MEET AGAIN WITH A. H. A.

THE ANNUAL meeting of the American Occupational Therapy Association, which met for the second year in conjunction with the American Hospital Association, was in all respects the best meeting ever held by the association. The proceedings occupied three full days in Milwaukee and a day of visits to hospitals in Chicago, where the Illinois Association of Occupational Therapists were hosts to a large number of members of the national organization.

The exhibition of the work of occupational therapy sent in to the conference by more than fifty hospitals showed remarkable progress, and was at all times during the convention a center of attraction to everyone attending the A. H. A. conference.

Special mention must be made of the program, which was issued in the form of a souvenir number of the Wisconsin Journal of Occupational Therapy, the organ of the Wisconsin association. In addition to the program, a wealth of information on the extent of the work in Wisconsin was included in the souvenir number. The Wisconsin association defrayed the cost of printing this attractive souvenir program, and the cost of arranging the fine exhibition of work.

A committee of the Illinois Association of Occupational Therapists, under its president, Mrs. Frederick Dale Wood, undertook the details of the registration and provided convention badges for the members and visitors.

The opening session, October 30, was devoted to the reception of reports from standing and special committees, all being of great value and interest.

Exhaustive Report on Materials

Particular mention must be made of the report of the committee on installations and advice. Miss Harriet A. Robeson, late director of the Massachusetts Occupational Therapy Association and now head of the department in King's Park State Hospital, Long Island, N. Y., chairman, presented a very exhaustive report on equipment and materials required for departments of occupational therapy in hospitals of all types and various bed capacity. This report will undoubtedly prove to be one of the most valuable contributions made by the association and will be published.

The committee on research and efficiency, Miss Idelle Kidder, Terre Haute, Ind., chairman and late director of the Missouri Occupational Therapy Association, presented an interesting report of investigations made in hospitals of many kinds to determine, if possible, some definite ratio of aides to patients. Prominent hospital authorities, federal, state, municipal and others, contributed other views, but it does not appear possible at present to lay down very definite requirements as to the number of patients for which one worker should be responsible. The report was valuable, however, in that the inquiries of the committee have undoubtedly led many hospital authorities to study the question and, in some cases, to decide upon a ratio of patients to workers to meet the needs of the particular hospital or system concerned.

The committee on teaching methods, Miss Ruth Wigglesworth, Boston School of Occupational Therapy, chairman, reported on training schools which are at present in the United States, all well-organized and successful institutions. The committtee on publicity and publications, Dr. William R. Dunton, Jr., chairman, Sheppard and Enoch Pratt Hospital, Towson, Md., reported on the progress of the official organ of the association, *Archives of Occupational Therapy*, now in its second year. A strong editorial board, with corresponding members in many countries, under the chief editorship of Dr. Dunton, is producing a bi-monthly magazine which is attracting subscribers from countries, as far distant as New Zealand. The committee has also prepared various bulletins of information for distribution to the members.

Submit Tentative Budget

The financial committee, Dr. William L. Russell, Bloomingdale Hospital, White Plains, N. Y., chairman, submitted a report and a tentative budget for the ensuing year, providing for a large extension of the association's activities and usefulness. The report had already received the formal endorsement of the board of managers, and was unanimously adopted by the members. Special efforts will be made to procure additional funds for the proposed budget, to enable the work of the association to be extended as recommended.

The report of the secretary-treasurer, Mrs. Eleanor Clarke Slagle, director of occupational therapy, New York State Hospital Commission, was a most comprehensive, clear and complete statement of the work of the past year, and was formally adopted by the board of managers before being presented to the members at the meeting. The report showed the total number of members in good standing on October 23, 1923, to be 588.

Inquiries from Foreign Countries

Many inquiries were received during the year from hospital authorities desiring information regarding the establishment of departments of occupational therapy, and for the further development of existing departments. These inquiries came not only from the United States and Canada, but from India, China, Japan, New Zealand, Holland and Great Britain.

The report emphasized the need for a full-time, paid, assistant secretary, and of funds for the frequent publication of bulletins of information to the members and other much needed extensions of the present activities of the association. The report was unanimously adopted and a hearty vote of thanks and appreciation tendered to Mrs. Slagle for her work, a labor of love, performed in addition to her exacting professional duties in building up and developing the fine system of occupational therapy in the hospitals of the New York State Hospital Commission, with a patient population of nearly forty thousand persons.

Association Adopts Pin

The committee on insignia, chairman, Miss Ruth Wigglesworth, reported that its labors had been concluded and received the thanks of the association. An artistic emblem has been designed by a leading art worker and is now available in the form of an attractive pin for the use of the members.

A special committee on education, Miss Susan Johnson, New York, chairman, presented a report embodying the returns from a questionnaire on the use of occupational therapy in hospitals, supplementing a report submitted at the last annual meeting.

The afternoon session on the opening day marked the

public opening of the convention which began with an invocation by the Rev. F. G. Behner, secretary of the general federation of churches. An eloquent and appropriate address of welcome was then delivered by Dr. George G. Ruhland, commissioner of health for the city of Milwaukee.

The president of the association, Mr. Thomas Bessell Kidner, New York, N. Y., followed with an address, which included a review of the history of the association and of the activities of the past year and some future aspirations for the association. It is of interest to note that of the original group of incorporators of the association all but one (deceased) are still active in its affairs.

In his address the president dealt in particular with some of the tendencies in occupational therapy and emphasized the necessity for sane, national leadership by the association, if the work is to continue and develop to its full possibilities in the treatment of the sick and disabled. Mentioning some directions in which such leadership is necessary, Mr. Kidner said:

Denounces Commercial Aspect

"There is a strong tendency, for example, in many places to make our work purely commercial. That is to say, instead of the object which the patient produces during his treatment by occupation being regarded as incidental, the production of an object for sale becomes the main aim. What does this mean? It means that inevitably the success of the occupational therapist will be measured by the sales made. In turn, this will react on the work, from the fact that it is almost inevitable that a worker who is to be judged by her success in producing articles for sale, rather than in restoring a patient's interest and powers, will devote attention to patients able to produce and will neglect the patient for whom occupational therapy may be of enormous benefit, although the outward and visible signs, i. e., the articles made, may be of poor quality and unfit for sale.

"It cannot be pointed out too strongly, however, that superintendents and hospital authorities who look to the immediate economic end of the craft work are entirely unmindful of the fact, proved beyond cavil in many places, that the period of hospitalization of many patients may be considerably shortened by the intelligent use of occupational therapy. In that way, the end result is incalculably greater, even from a purely economic standpoint, than when attention is concentrated on the production of salable articles.

"We must never forget that it is occupational therapy and not commercial production that we are engaged in. In saying this, I am entirely aware of the therapeutic value to a patient of being able to produce a salable article, for I have known many patients, disheartened and unnerved for the future by a long illness, who have renewed their faith in themselves because of their having produced an article which some person was willing to buy for its intrinsic value quite apart from any sentiment which might arise from its having been made by a person handicapped by illness or injury.

"On the other hand, great possibilities have been opened to occupational therapy by the working of the Industrial Rehabilitation Act. Indeed, I think it is fair to say that many hospitals have had their attention drawn to the value of occupational therapy by the federal and state industrial rehabilitation authorities, who are doing their best to place persons disabled by accident or disease in industry, back again at work in some occupation at which they can be efficient, in spite of the handicap of their disability. But here again we must be on our guard. Undoubtedly in our therapeutic occupations much can be done, and has indeed already been done for years in some places, in pre-industrial and pre-vocational work, but we cannot, in the very nature of things, go beyond that and turn our hospital curative workshops into vocational schools.

Difficulties of Vocational Training

"In the first place, if there were no difficulties in the way as to qualified instructors and suitable (and very expensive) equipment, there is the prime objection that, at best, vocational training can only appeal to a limited number of patients. But no one who really understands the very great difficulties of providing vocational training under normal conditions for well people can be under any illusions as to the impracticability of doing it to any helpful extent in our hospitals. Were it not really pathetic, it would almost be laughable to hear the claims sometimes made to visitors to hospitals that some simple work carried out by a patient is training him for a gainful occupation after his discharge. Such claims are all too often a measure of the want of real knowledge of industry on the part of those who make them. We have plenty to claim for curative work without making unwarranted statements as to its being vocational training.

"Another field which has as yet been scarcely scratched is in work for handicapped children. In our large cities and towns there are thousands of children who would benefit greatly if occupational therapy could be taken to them in their homes to which they are confined as cripples. In time, this would develop in many cases into actual training for some productive work of a simple kind, although the work may have been given at first wholly for its therapeutic value. These remarks apply equally to home-bound adults, and I note with pleasure that we are to have papers at subsequent sessions from leaders in

Members who attended the second annual convention of the American

both of these phases of our work."

In speaking on necrology, Dr. Dunton paid touching tribute to three members who have died since the last annual meeting: Dr. Herbert J. Hall, Marblehead, Mass., a former president of the association; Mr. George Edward Barton of Clifton Springs, N. Y., one of its founders, and Miss Dorothy Whitmore, an active member.

Representatives of cooperating organizations then made addresses as follows: For the Junior League of Milwaukee, Miss Wariner; for the Wisconsin Anti-Tuberculosis Association, Dr. Hoyt E. Dearholt; for the Industrial Rehabilitation Division of the Wisconsin State Board of Education, Mr. Harvey.

The presentation of an important and valuable report on forms and records by a special committee headed by Dr. Horatio M. Pollock of the New York State Hospital Commission, was the last item on the afternoon program. Simple but adequate forms covering all the needs of an occupational therapy department were submitted by the committee and adopted for early publication by the meeting, which also recorded its high appreciation of the work of Dr. Pollock and his associates on the special committee.

The evening was delightfully spent in a visit to the occupational therapy training school at Milwaukee-Downer College, followed by a reception to the members by the faculty of the department.

Willow Work in State Hospitals

A consideration of the relation between occupational therapy and vocational and industrial rehabilitation featured the morning program of the second day's meeting of the occupational therapy association. A paper on "The Pre-Industrial Value of Occupational Therapy in Mental Hospitals," was read by Dr. Foley, Chicago, Ill., who described the curative work in the pre-industrial shops at the Chicago State Hospital with which he is associated. He showed how the pre-industrial shops are valuable in helping persons who may later be discharged to learn some useful and gainful occupation. Willow basketry and furniture made from the trees grown on the grounds is an important part of the work there. This was started as a war emergency measure but has continued because of the valuable out-door work which it affords patients as well as because of the value of the products.

In discussing the importance of this willow work, Mrs. Eleanor Clarke Slagle, who planted the first willows at the Chicago State Hospital, said that 25,000 slips had recently been planted at some of the New York State Hospitals with which she is familiar as the director of occupational therapy for the New York State Hospital Commission.

Mr. Walter J. Hamilton, Chicago, Ill., the well-known industrial and vocational personnel counsellor, gave an address on what the occupational therapist should know of the agencies of rehabilitation outside of the hospital. Federal and state authorities in nearly forty states are now cooperating in the industrial rehabilitation of persons disabled in industry by accident or disease. The rehabilitation of disabled persons, he pointed out, calls for close cooperation and coordination of all concerned; the physician, the nurse, the occupational therapist and physiotherapist, the vocational counsellor, social agencies, the official agencies of rehabilitation and the employers.

An excellent paper by Mr. A. Foulkes, the officer in charge of industrial rehabilitation under the Wisconsin State Board of Education, was read by his assistant, Mr. Harper, who described the fine cooperation already existing in this field in Wisconsin. A paper on the same subject by Mr. F. G. Elton, state rehabilitation officer in New York City, was read by title in Mr. Elton's absence.

An inspiring presentation of the work for crippled children being carried on at the Jesse Spaulding School in Chicago, was given by the director, Miss Jane A. Neill. The right of every crippled child to the fullest and best education of which he is capable was stressed, not as charity, but to make useful citizens who would otherwise be a tax on the community. A fine collection of lantern slides by which Miss Neill illustrated her paper gave the members evidence of the results which work for crippled children will bring, if intelligently and conscientiously directed.

The afternoon session on October 31 was held at the National Military Home, in the new tuberculosis hospital unit of 500 beds. The fine shops, classrooms, and recreation quarters elicited many expressions of admiration from the visitors.

Urges Care in Curative Work

Major B. E. Hedding, chief of tuberculosis service of the National Home, gave a talk, "Is It Occupational Therapy?" Speaking from some years of experience of the application of occupational therapy in the treatment of tuberculous patients, Dr. Hedding urged that curative work should be given only on the prescription of the physician in charge of the case. He had been long ago fully convinced that of the two or three new therapeutic treatments for tuberculosis evolved during the past twenty years, occupational therapy was the chief and best treatment.

Under the general title of "Recreation and Music as Occupational Therapy," two most helpful papers were presented. The value and necessity of recreation were set forth in a most inspiring way by Mr. R. K. Atkinson, Russell Sage Foundation, New York, N. Y. Not only is

Association of Occupational Therapy held in conjunction with the A. H. A., at Milwaukee, Wis.

recreation spiritually and morally necessary, but it has direct therapeutic value, particularly in mental and nervous cases. Group exercises, folk dances and similar activities, often help to restore the power of coordination in serious cases of mental and nervous derangement.

The director of occupational therapy, U. S. Veterans' Hospital, St. Paul, Minn., dealt with the subject from the point of view of the use of music, both with recreation and apart from it. Interesting records of cases which had definitely benefited from music were given. Music has also proved to be valuable in veterans' hospitals as a pre-vocational subject, and a number of disabled men who discovered their aptitude for music during their period of hospital treatment are now taking definite training in music as a profession or a gainful occupation.

About 300 members were present at the annual banquet held in the evening at the Milwaukee Athletic Club.

The third day's proceedings began with an exceptional paper by Dr. Herman Smith, superintendent, Michael Reese Hospital, Chicago, Ill., on "Occupational Therapy from the Point of View of a General Hospital Superintendent." Dr. Smith is a firm believer in the value of curative work in a general hospital, but deprecated the fact that some over-enthusiastic advocates of occupational therapy sometimes make extravagant claims for it. Dr. Smith believes that in many cases, while occupational therapy may have an excellent effect on the mind and spirit of a patient by diverting his attention from his sufferings, direct physical curative value is sometimes claimed in cases in which such claims are not warranted. Dr. Smith believes that in many cases occupational therapy may have a direct pre-vocational value, but in order to give the curative work that value, it is imperative that there should be the closest cooperation between the physician, the occupational therapist, the social worker and the outside rehabilitation agencies.

In a paper entitled "Occupational Therapy Associated with Industrial Injury Service," Mr. C. J. Glasser, of the French and Early Institution for Industrial Injury Services, Los Angeles, Cal., described the remarkable work being accomplished by the curative workshops in connection with this institution. Various forms of occupational therapy are employed and the actual period of disablement has been thereby reduced on an average of twenty per cent. The curative work forms an integral part of the hospital treatment in the institution, which draws its patients from many industrial establishments in Southern California, and has strong financial support from the large accident and compensation insurance companies.

One very remarkable result of the use of occupational therapy is that traumatic neurosis of the back, formerly very common in accident cases, has almost disappeared since occupational therapy has been employed.

Dr. Glenford T. Bellis, medical director, Muirdale Sanatorium, Wauwatosa, Wis., presented a helpful paper on "Occupational Therapy in the Sanatorium Treatment of Tuberculosis." Muirdale Sanatorium was one of the pioneers in the use of this form of treatment for tuberculosis; a department of "Diversional Industry" having been established in 1915. Dr. Bellis emphasized the need of prescriptions for work by the physician directly concerned with the case, and of careful individual attention throughout. The paper brought forth a very interesting discussion, led by Dr. E. L. Mariette, medical director, Glen Lake Sanatorium, Hennepin County, Minn., another leading sanatorium where occupational therapy is successfully used for tuberculous patients.

"The Problem of Organizing Occupations Among the Home-bound" was the title of a deeply interesting and very practical paper by Mrs. Grace Pebbles, of the Vocational Society for Shut-ins, Chicago, Ill. Mrs. Pebbles emphasized the great need for a wide extension of this work in all centers of population and gave many practical suggestions as to methods of organization and maintenance of work for cripples and other invalids confined to their homes. Of necessity, such work must have a definite commercial value, and many helpful hints were given as to the best method of disposing of the articles produced by the home-bound workers. Records of a number of cases of various types giving the economic and social results of treatment, completed a very constructive paper.

Immediately at the close of the morning session the members journeyed out to Wauwatosa, where they were the guests of the county authorities at luncheon in the dining hall of Muirdale Sanatorium. During the luncheon three-minute reports were given by members from most of the states. Everywhere progress is being made, as was evidenced by the talks of the speakers. Visits to the occupational therapy department in the Muirdale Sanatorium and to the fine and attractive curative workshop at the County Hospital for Mental Diseases followed. Dr. G. F. Bellis of Muirdale and Dr. Young of the County Hospital formally welcomed the visitors and received their hearty thanks for the excellence and completeness of all the arrangements made for their entertainment and instruction.

Round table discussions filled the rest of the day. Dr. W. R. Dunton, Jr., Sheppard and Enoch Pratt Hospital, Towson, Md., presided over the discussions on work in mental hospitals.

Mrs. Gertrude Sample, chief of the occupational service, U. S. Veterans' Hospital, Oteen, N. C., was chairman of the round table on work in tuberculosis sanatoriums.

Occupational therapy in general hospitals formed the subject of the discussion at a round table presided over by Miss Elsie Hassenstein, director of occupational therapy, Cook County Hospital, Chicago, Ill. Mrs. Grace Pebbles, of the Vocational Society for Shut-ins, Chicago, presided over the group discussions on work for the home-bound.

The officers elected for the year are as follows: president—Mr. Thomas Bessell Kidner, National Tuberculosis Association, New York, N. Y. (re-elected); vice-president—Dr. G. Canby Robinson, Johns Hopkins Medical School, Baltimore, Md. (re-elected); secretary-treasurer—Mrs. Eleanor Clarke Slagle, director of occupational therapy, New York State Hospital Commission, New York, N. Y. (re-elected); Board of Managers—Dr. Philip King Brown, Arequipa Sanatorium, San Francisco, Cal. (re-elected); Dr. B. W. Carr, chief, division of occupational therapy, United States Veterans' Bureau, Washington, D. C. (re-elected); Mrs. Carl Henry Davis, Wisconsin Occupational Therapy Association, Milwaukee, Wis. (re-elected); Mrs. Elias Michael, Missouri Occupational Therapy Association, St. Louis, Mo. (re-elected); Dr. H. M. Pollock, State Hospital Commission, Albany, N. Y. (re-elected); Dr. Frankwood E. Williams, National Committee for Mental Hygiene, New York, N. Y. (re-elected); Dr. W. R. Dunton, Jr., Sheppard and Enoch Pratt Hospital, Towson, Md.; Mrs. Fred W. Rockwell, member of board of managers, Philadelphia School of Occupational Therapy, Philadelphia, Pa.; Mrs. Frederick Dale Wood, president, Illinois Society of Occupational Therapists, Chicago, Ill.

Hearty thanks were unanimously voted by the members to the Wisconsin Occupational Therapy Association for the splendid services rendered in making such complete arrangements for the convention, and in particular for the fine souvenir program.

HOSPITAL DIETETIC COUNCIL HOLDS FIRST ANNUAL MEETING

WIDE interest in the problems of the hospital dietitian was shown at the first annual meeting of the Hospital Dietetic Council held in conjunction with the American Hospital Association at Milwaukee, Wis., October 29 to Nov. 3. The first session was opened by Miss Rena S. Eckman, president, who addressed the council. The invocation was pronounced by the Rev. Gustav Stearns, chaplain, Milwaukee, Wis. The address of welcome which followed was given by Dr. I. F. Thompson, public health officer, Milwaukee, Wis., who expressed his approval of a nutritional service in lowering the number of cases of diabetes and nephritis, analagous to the present results of the medical men in stamping out infectious diseases. The remainder of the meeting was given over to reports of the president, secretary, and committee on publications.

The meeting Monday evening was conducted by Miss Bertha Wood, first vice-president of the council. The first speaker on the program was Dr. Hermann Smith, superintendent, Michael Reese Hospital, Chicago, Ill., who read a paper on "How the Hospital Dietitian May Have Contact with Administrative Problems." In this paper Dr. Smith spoke of the change in the accepted work of the dietitian from the teaching of nurses and the preparation of special diets, of a few years ago, to the present day when most dietitians have the full food responsibility.

Mrs. John Henry Martin, Miss Margaret Drew, Miss Hilda Reinhold, Miss Margaret Forthergham and Miss Irene Willson of the Hospital Dietetic Council.

This responsibility brings with it many administrative problems, and Dr. Smith spoke particularly of the problems of the distribution of weighted trays to the patients and the charting of these foods. "Only by strict and continual supervision," said Dr. Smith, "can these trays be correctly and properly handled, and this service should be given by the dietitians." This will probably mean an enlarged department personnel. Dr. Smith suggested the possibility of an extra charge, temporarily at least, to meet the added financial burdens. To solve this and other administrative problems the dietitians must have ability as well as a great deal of tact in order that the service may so function as to avoid friction with the nursing and general administrative departments of the hospital.

"Hospital Architecture and the Department of Dietetics," was convincingly treated by Mr. Perry W. Swern, hospital architect, Chicago, Ill. Mr. Swern has a firm belief in a central serving kitchen. He especially advocated the location of "service lifts" in relation to the floor plans of the hospital. This plan is no more successful than the old system of floor serving kitchens unless the service lifts are stationed far enough apart to shorten the distance from them to the patient's bedside.

The meeting Tuesday morning was conducted by the president. Dr. John R. Williams, Rochester, N. Y., read an interesting paper on "Instruction of the Diabetic Patient." The patients under his care are taught the importance of the treatment of diabetes, the value to the patient of rest, exercise and diet, the importance of continuous dietary control, and the necessity of an intelligent regulation of insulin therapy. They are also taught how to care for and store foods, so that they may have the proper foods the year round. Stress is likewise laid on the possibility of modifying the entire family diet to meet the needs of the diabetic. Lectures are given to show the importance of the care of the bodily functions of the patient. Instructions are given in collecting samples of urine and in simple urinalysis.

Different types of diabetic foods and medicines are exhibited, and the patient is instructed as to which to use and which to avoid. He is likewise taught how to make soy bean and casein flour, and taught how to use scales in the weighing of his diet. Sometimes they are shown exhibits of various types of salads, of breadstuffs and of a complete palatable meal suitable for a family of six, in order that they may realize just how simple the family diet may be adjusted to fit that of the patient.

Miss Mary A. Foley, Mayo Clinic, Rochester, Minn., in a paper on "Instruction of the Diabetic Patient as Interpreted by the Dietitian," brought out the point of the importance of starting the instruction of the patient even before he gets his first tray, so that he does not receive at the start foods which he dislikes and to which he is unaccustomed. The importance and significance of keeping to the diet should be emphasized, she said, and this is often done by having the ambulatory patients get together in lectures, in demonstrations, in the laboratory and in cooking classes.

In the discussion of these papers, Miss Wood emphasized again the point that we are getting away from standardized treatment of all cases, and are teaching each patient as an individual.

Miss Margaret Hoffman, Cleveland, Ohio, made the point that in feeding our hospital cases we often give too much variety with each meal, so that the patient is unable to afford the same type of thing when he returns home. Large servings of one or two vegetables might be given in place of four or five different ones.

Dr. Leonard G. Rowntree, Mayo Clinic, Rochester, Minn., presented the dietitians with the "Bible" the name of the most important book on dietetics. In this book the study and knowledge of food stuffs was traced down through history to the present time.

He brought out that the public must be educated that our meals are not only to be balanced in the elements, but also the accessories and salts must be present in full requirement. They should know the limitations set to prevent disease. The public should be able to correct their

meals that are qualitatively right and quantitatively wrong; or meals that are both quantitatively and qualitatively wrong.

Dr. A. B. Denison, Lakeside Hospital, Cleveland, Ohio, read a paper on the contribution which the hospital through its department of dietetics may make to the community. "The hospital," said Dr. Denison, "is a cooperative machine and the services of any one department must be carried through all parts of the institution. The obligation of the hospital does not cease when the patient leaves the institution, but must follow the patient into the home and try to help make the necessary adjustments. There must be the closest cooperation between the departments of social service and dietetics, in the problems of educating the patient and of trying to postpone hospitalization."

"We have only begun to utilize the possibilities of the dietitian," said Dr. Denison. "It lies in her power to develop these possibilities, to build slowly, and organize each step thoroughly."

The meeting Wednesday morning was called to order by the president, who introduced Dr. Paul Kind of the Knox Gelatine Co., who gave a brief talk on the recent research work which has been done on gelatine. The use of gelatinized milk in infant feeding has brought very good results, and further work is to be done with school children.

Miss Marjorie Northrop, a representative of the Armour company, read an interesting paper on "Some Possibilities of Unusual Meats on the Institutional Menu." The possibility of using the cheaper cuts of meats to make appetizing and attractive dishes and also the desirability of using the selected meats, as heart, liver, kidneys and sweetbreads, were points made.

Mrs. J. H. Martin, St. Paul, Minn., read a paper on the "Nomenclature of Diets" in which a brief resume of the general controversy as to the contents of liquid, semi-solid, light and general trays was given. The fact was emphasized that a general standard should be adopted to prevent waste or lack of food at the serving diet kitchen and that this would aid both doctors in writing, and the dietitians in carrying out, the doctor's orders.

In order to acquire standardization, a committee was appointed to work out a method of research which is based on the coefficient of digestibility.

On Wednesday evening Dr. Solomon Strouse read a paper on "The Need for Diet Control Accompanying Insulin Administration," in which he first reviewed the different methods of treating diabetes which have been used since 1796. The insulin treatment has in no way lessened the burden of the dietitian," he said, "but has rather increased the need for careful diabetic care. The importance of complete dietary control cannot be overestimated. The patient should be freed from sugar before insulin is used as in this way it is possible to build up the diet and reduce the amount of insulin more easily." It is too early, according to Dr. Strouse, to tell if this is permanent, but at least the insulin enables the patient to return to work, and keeps him happy.

Dr. S. Franklin Adams, Rochester, Minn., in discussing this paper, brought up the possibility of giving insulin to the young mild diabetic when in the older mild diabetic it may not be necessary.

Dr. Julius Hess, Chicago, presented a paper dealing with "Problems in Feeding of Infants and Children." Dr. Hess said that there is no substitute for mother's milk; but that the problem of modification of cow's milk can not be ignored. Too often advice of various food manufacturers is followed by ignorant mothers with disastrous results. Dr. Hess reviewed briefly the development of milk modifications from the percentage method to the caloric requirement method, now widely used and first practiced by the German school. Mention was made of the use of gravity cream and skim milk; but it was pointed out that this method necessitates close calculation and that digestive disturbances are more apt to arrive than when whole milk, water and sugar are used.

Dr. Hess mentioned the effect of pasteurization on the anti-scorbutic value of milk and emphasized the necessity of adding fruit juice, orange being the most practicable, when using pasteurized milk; he also specified the ages at which cod liver oil, cereal, vegetable and fruit juices might be introduced into the diet.

There can be no hard and fast rule laid down for the feeding of infants, he believes, because infants differ in the use of individual food. Every formula should be considered as an experiment and careful clinical observation made.

Miss Margaret Drew, Sioux Falls, S. D., led the discussion on therapeutic diets on Thursday morning.

Officers and committees for the year were elected at the business meeting, Thursday afternoon.

The officers are: president, Miss Rena S. Eckman, Michael Reese Hospital, Chicago, Ill.; first vice-president, Miss Bertha M. Wood, East Northfield Seminary, East Northfield, Mass.; second vice-president, Miss Mary A. Foley, Mayo Clinic, Rochester, Minn.; executive-secretary. Mrs. John Henry Martin, Charles T. Miller Hospital, St. Paul, Minn.; treasurer, Miss Margaret Fotheringham, Mercy Hospital, Pittsburgh, Pa. The executive board consists of the above officers and the following: Miss Irene Willson, 1924, Miss Margaret Drew, 1924, Mrs. Dorothy Ayres, London, 1925, and Miss Gertrude Thomas, 1925.

A group of the hospital dietetic council: left, Miss Margaret Drew, executive board; left center, Mrs. John Henry Martin, treasurer; center, Miss Mary A. Foley, vice-president; right center, Miss Gertrude Thomas, executive board; right, Miss Dorothy Ayers, London, executive board.

DISTINGUISHED WORKERS APPEAR ON PROGRAM OF P. H. A. CONVENTION

THE PROTESTANT Hospital Association held its third annual convention, October 27 to 29, in the Hotel Pfister, Milwaukee, Wis. The convention was well attended by representatives of its hospitals from all parts of the United States and from nearly every state.

Outlines Aims of Association

In his annual address, the President, Dr. Charles S. Woods, superintendent, St. Lukes Hospital, Cleveland, Ohio, outlined some of the purposes of the association. "We have not created a place for our association," he declared, "but have entered a place which was already prepared for such an organization." He pointed out that the association aims to make Protestant hospitals conscious of their obligations and strength. It has turned the attention of the Protestant hospitals to their very definite function in the activities of the church. We are witnessing a very interesting development which means: first, a finer conception of the purpose of the church hospital; second, an awakening of the church to its opportunity to render service through its hospitals; third, an ever increasing support of these institutions; fourth, the development of well trained hospital workers, who are devoted, not only to the institution, but to the church of which the institution is but a part.

C. S. Woods, M.D., superintendent, St. Luke's Hospital, Cleveland, Ohio, who was re-elected president of the Protestant Hospital Association.

The report of the executive secretary, Dr. Frank Clare English, revealed that the work of his office is becoming increasingly heavy, while the membership is having a healthy growth. "At the close of the first year," he stated, "we had 101 members. The end of the second year found 170 on the roll, and when the third year ended, October 1, we had 230 members." His report showed that 4,750 letters went out from his office the past year, several thousand pieces of printed and multigraphed matter had been mailed, and an attractive thirty-six page program printed. "Such an organization as ours," he asserted, "is better than a fraternal organization. It is much like the reserve of life insurance membership or an accident policy, always there when needed by all who wish its benefits, as is shown by the large and constant demands upon the secretary's office for information and assistance."

"Some Economic Aspects of Hospital Service," was the subject of a paper read by Mr. J. B. Franklin, superintendent, Baylor Hospital, Dallas, Texas. He said: "Anything that conserves time, labor, materials, money or life is economic, in the broad sense of the word."

He lamented the amount of energy, labor, time and money that has been squandered in hospital buildings and in the manufacture and the purchase of equipment and supplies. He emphasized the need of standardizing equipment and supplies. Conservation of supplies by attendants, nurses and doctors throughout a hospital will mean a big saving. Monthly expense sheets, detailing the cost of maintaining each department, should be carefully kept and studied with the thought of making a better showing month by month. Every hospital should be both an educational and healing institution.

Miss Meta Pennock, editor *The Trained Nurse and Hospital Review*, New York, N. Y., read a comprehensive paper on "The Obligation of Church Hospitals to Student Nurses." She said that the nurse believes the church hospital is founded to express love and to equalize justice, and pointed out that the first obligation to the student is the establishment of sound, buoyant health, which means an increasing power to produce, to enjoy, to endure. The second obligation implies adequate educational facilities. The student nurse entering school is prepared to work and study and cannot utilize her full strength and endure her work without wholesome food, proper facilities and a healthful environment. She advocated for the nurse a thorough physical examination monthly and after any illness; food which will maintain the individual nurse at her highest working efficiency; the cultivation of health habits in regard to eating, resting and sleeping; and recreation of mind and body to counteract the physical and emotional strain of nursing.

The last and greatest obligation of the church hospital to its students, the obligation which differentiates it from all other hospital schools, is its responsibility for the spiritual growth of the nurses placed in its care. It must give them a working philosophy of life," concluded Miss Pennock.

Dr. A. O. Fonkelsrud, superintendent, Trinity Hospital, Minot, N. D., spoke on the subject of inter-denominational hospitals. Dr. Fonkelsrud persuaded his audience that the churches of any community can unite in the care of their local hospital.

The "Good Samaritan" Idea

Dr. James H. Alexander, Charlotte, N. C., handled the subject of the "Good Samaritan." He said: "Any charitable organization or individual, be he doctor, nurse, or what-not, will feel it an honor to have bestowed upon him the name of 'Good Samaritan.' A large number of institutions bear this name today. It would seem as if this character represents a perfect attitude."

"The Organization of a Case Record Department," was the subject of an address by Dr. John Wesley Long, Wes-

ley Long Hospital, Greensboro, N. C. He declared that, "Without records the work of a hospital is like a rope of sand; it breaks of its own weight, having no cohesive force, no tensile strength, no continuity. If a hospital does not have a case record department, to whom would one go for the desired information?" In order that a case record department shall function efficiently, he proposed first, that the scheme should contemplate that the records be truthful; second, simple so that a wayfaring man can read as he runs; third, they should embody common sense; and fourth, be adjudged scientifically.

One of the striking features of the convention was an illustrated lecture by Dr. Malcolm T. MacEachern on hospital standardization. The differences between the standardized hospital and that which is not were effectively shown by pictures, charts and graphs. The association pledged itself not only to seek the minimum standard but to go on to the maximum.

Field Work—Best Advertising

"Field Work for Hospitals" was the subject of a paper by the Rev. S. E. Ewing, Baptist Sanitarium, St. Louis, Mo. "A satisfied customer is the best sort of advertising for a hospital as for a business," he declared, "and as in a college, so in a hospital the personal touch counts for everything. Patients and nurses come to us for various reasons and we recognize that the only thing we have to sell is service—a service so unique, unselfish, homelike and Chrisitian that folks will want to come to our institution. Here again we refer to the importance of a satisfied customer. Scores and scores come simply because a former patient was satisfied."

"The publicity of a hospital is of vast importance," he continued. "The publication of a quarterly giving inside information is of great value. Patients and graduate nurses are our greatest asset in advertising the merits of the institution. The free work done by our sanatorium or hospital can well be made a strong talking point by the field worker. Mr. Ewing concluded by saying that in securing student nurses we have found that by lifting the standards we have been able to secure students more easily.

The Rev. W. H. Jordan, Asbury Hospital, Minneapolis, Minn., discussed this subject and gave much light upon the real work of the field secretary. He said, "Field work for hospitals is now coming to have its just importance and recognition. By this method a church institution can maintain a close relationship with its constituency. The field secretary is a vital factor in all our larger institutions, as he is a point of contact, connecting the people with the hospital. He corrects many misconceptions as to the purpose and manner of service of our hospital. Nor is he more valuable in the field than to the board of management. He becomes a shock absorber and frequently stands between the hospital and any hostile attack. The true field secretary must be a man of broader vision and purpose than that which centers around his own institution.

Social Service in Church Hospitals

Miss Louise M. Reinier, director of social service, Woman's Hospital, New York, N. Y., read a valuable paper on "The Place of Social Service in Church Hospitals," which stirred the convention with an impulse of greater service to humanity. "In the care of the sick," she said, "the proper place for social service to begin in a hospital is at the front door, and from that same front door to follow the patient upon her discharge." She pointed out that since social service fits logically into the duties of a hospital, it is evident that the department should have a definite place in the hospital organization. The most efficient work will be done when the social service department is an integral part of the hospital organization. Every patient able to pay to private doctor should be refused admission to the clinics; but of greatest importance, social service in the Protestant hospital should reach the needy through that sympathy which springs not out of charity but out of love. "Members of the Protestant Hospital Association, I appeal to you, let this place of social service in your hospitals be first in your hearts, in your minds and in the soul light of your institutions."

Real Work of the Superintendent

Mr. E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago, Ill., spoke on "Some Duties of Hospital Administration." He defined administration as that which serves or that which ministers unto. "By a curious twist of the American mind, it has come to mean, that which orders, directs, supervises. However, the preponderance of opinion seems to be that the superintendent is one who is in charge. To whom does he owe duties? To the medical staff, to the school of nursing, to the employees, to the patients, to the friends of the patients, and to the public. His is a real job. His first duty is to organize. The accounts of the hospital should be so kept that a complete record of income and expense of each department is always before him. The superintendent should not be the purchasing agent."

"When his hospital is well organized and his expenditures controlled he is in a position to plan for a bettering of conditions. There should never be any discord between him and the school of nursing for every department must recognize him as the superintendent. There cannot be two heads in any institution. The patients' welfare must be the first consideration and next to that comes the nurses' welfare. So far as possible, the superintendent should know the patients and mingle with them, studying their needs. Some superintendents know so little of psychology that they count the friends of their patient as so many thorns in their administrative sides. But in them really lies the possibility of much good for the hospital. The best way to gain public approval is to so conduct your hospital that the public, the patients' friends, the patients, the employees, the nurses, the staff, the trustees, and your own brain and conscience will say that justice, sympathy, thoughtfulness, kindness, and common sense rule therein."

Hospital Service Offers Career

The round table discussions of the conference were counted of very great value and many of the most vital subjects were discussed. Mr. Pliny O. Clark, Denver, Colo., discussed the subject, "Hospital Service as a Career," in a paper which he read before the association. He made it very clear that the hospital offers one of the greatest opportunities for service of any work and appeals strongly for well trained workers.

The convention closed by electing the following persons as officers for the coming year: president, Dr. Charles S. Woods, superintendent, St. Lukes Hospital, Cleveland, Ohio; vice-president, Dr. B. A. Wilkes, superintendent, Baptist Sanitarium, St. Louis, Mo.; executive secretary, Dr. Frank C. English, St. Luke's Hospital, Cleveland, Ohio; trustees: Dr. C. S. Woods, Dr. B. A. Wilkes, Dr. J. H. Moharter, Dr. A. O. Fonkelsrud, and Dr. J. H. Bauernfeind. New members executive committee are the following superintendents, J. R. Jolly, L. G. Reynolds, Thomas A. Hyde, and C. S. Pitcher.

EXPOSITION OF EQUIPMENT AND SUPPLIES ONE OF OUTSTANDING MERIT

THOSE who attend the convention year after year know that the exposition of equipment and supplies has been growing in size but the number of exhibitors and the variety of products exhibited at the silver jubilee convention surpassed even the expectation of those in attendance.

The exhibits were well arranged with ample space inside the booths and in the aisles so that at no time was there any crowding. There was always plenty of opportunity for the convention visitor to stay as long as he desired at any one booth or an especially interesting section of the exposition hall. The people of Milwaukee are to be congratulated on the possession of such a well-arranged auditorium, which is not only well adapted to conventions but almost perfect in the items that contribute to comfort. The lighting, ventilation, and temperature of the halls gave satisfaction to both exhibitors and delegates.

While there were nearly twice as many exhibits as at any previous convention there was no one section of either hall that drew interest more than another. Small groups would be found everywhere, for there were interesting products to see and new facts to be learned at all booths.

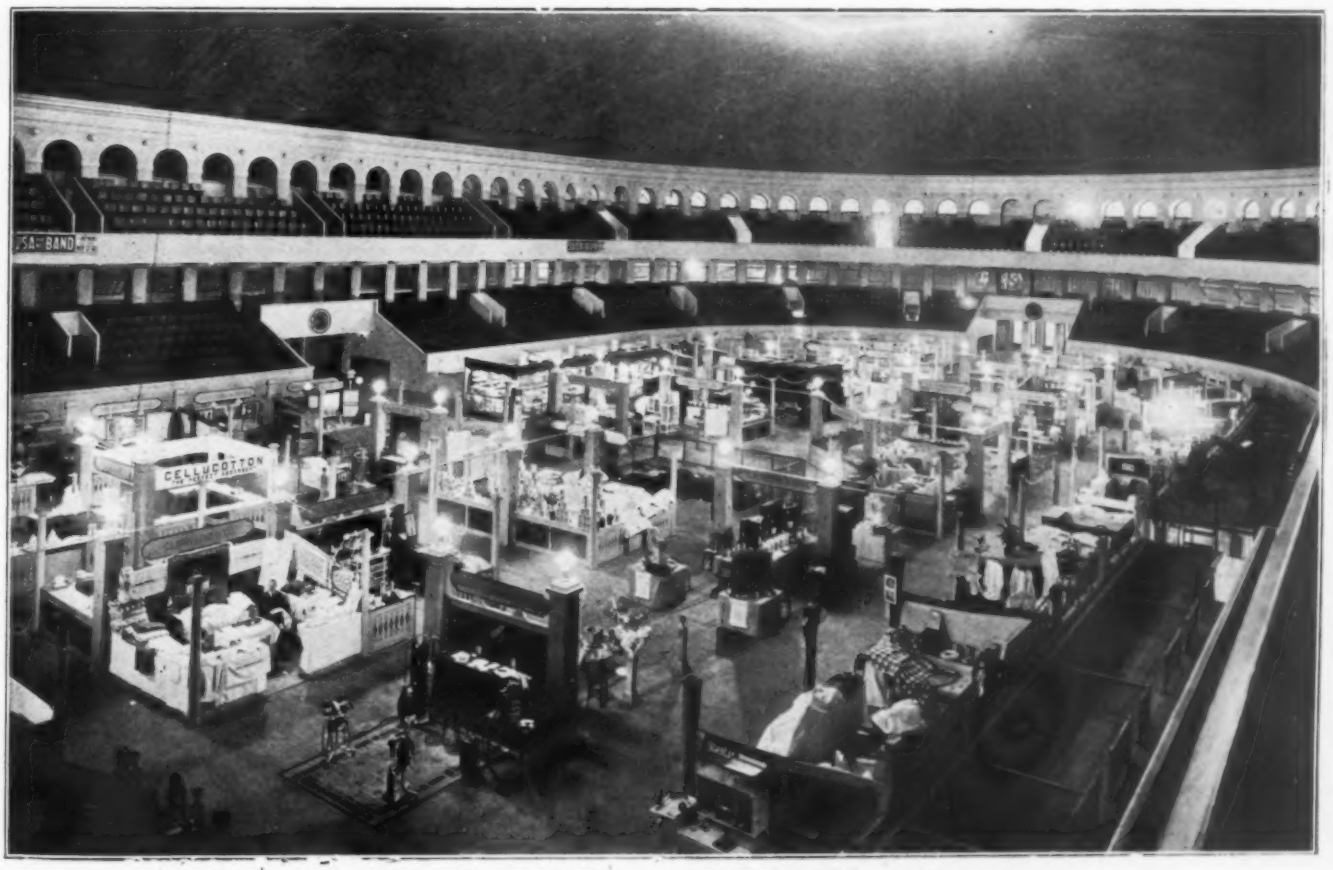
It is pleasing to learn that constructive criticisms of the 1921 and 1922 expositions were justified and largely corrected at Milwaukee. The variety of products was so great that nearly every visitor found what he wanted to examine.

Wide Interest in Building Materials

A great deal of interest was shown in the various products needed for new hospital building. Construction materials, such as various kinds of floorings, laundry chutes, garbage and waste burners, telephone and signal systems, lighting fixtures, special door handles, plumbing equipment, sound-deadening treatment for walls and ceilings, were well represented. In view of the big building program just ahead in the hospital field, there are a number of construction and building equipment products that should be represented at future expositions.

The model kitchen and model laundry were two special exhibits which were fairly complete in the range of equipment, although not arranged as many expected. The equipment in the model kitchen included cooking ranges, refrigerators, food slicers, mixers, ice cream freezers, and various baking equipment. In this space were a good number of items but they were not arranged in any manner that would be of assistance to a superintendent who wanted ideas on the layout of a model kitchen. The laundry exhibit contained the usual machinery and, while there was practically no new equipment, many machines well known in the hospital field had minor improvements and changes that proved of interest.

The products under the head of general furnishings and supplies were of great interest and were quite complete. There were several lines of bedroom metal furniture. Beds, casters, mattresses were shown, and a good display of linen towels, blankets and various other textiles. The house cleaning department was well represented with plenty of interesting and useful supplies for the janitor. Useful paper goods were well displayed, including paper



A gallery view of exposition hall as it was lined with booths at the convention.

towels, trays, napkins, surgeons' caps and similar articles.

As in former years, the display of clinical and scientific equipment and supplies was the largest of all. There were many of the well-known products and some very interesting and novel items new to the field.

The food display was small. An outsider might wonder if hospital patients eat only canned goods and gelatine and drink only special beverages. In some way or another the people of the food products industry do not seem to appreciate the vast market represented by the hospital field, judging from the small number of food exhibitors at the hospital convention. However, size was made up for by the quality.

Year by year, the commercial exhibits are of great interest and value to the superintendent, architect, trustee and all hospital people. Here under one roof and at their convenience they have the opportunity of asking questions about various products, of seeing what is new and of meeting many of the representatives of firms with whom they do business. Judging from the number of orders booked at the convention, superintendents also desire to place definite orders as well as to examine the products. This too makes the commercial exhibit well worth while to the hospital administrators.

There were about a dozen non-commercial exhibits including the exhibits of the American Medical Association, the American Library Association, the American Occupational Therapy Association, the Hospital Library and Service Bureau and the National Hospital Day Committee. Some of these exhibits are described in this issue, accounts of others will appear in our December issue.

EXPOSITION INCLUDES MANY NOVEL FEATURES*

THE EXPOSITION of the American Hospital Association conference at Milwaukee was the most comprehensive and interesting display of equipment and supplies for hospitals ever seen in this or probably any other country. Much credit is due to the officials of the association and to the committee of the exhibitors' association in making such an exposition possible. At all times it was evident that the manufacturers and dealers were in full cooperation with the association in making this an educational exhibit. The groupings of the exhibits were well planned, the heavier equipment being placed on the ground floor in Mechanics' hall, and the smaller items on the first floor.

One could not but be impressed with the general spirit of cooperation and the desire on the part of the exhibitors to furnish information in explanation of details of manufacture and uses of products and equipment displayed. Certainly all hospital people whose privilege it was to attend the convention are to be congratulated on the opportunity which was offered for studying so great a variety of mechanical, technical and scientific equipment and supplies representing not only standard requirements of hospitals, but also illustrating the most recent advances in each of the various lines.

Thanks to the analytical study of hospital requirements which resulted in the classification of hospital purchasing into the six natural divisions,** it was possible for the writer to view the 1923 exposition with a mind open to receive impressions which logically classified themselves, almost automatically, into one of the six established groups. No attempt will be made here to discuss equipment and other products already well-known to the writer; the purpose is rather to set forth the outstanding impressions of improvements, modifications, and new ideas which appealed especially to him.

SECTION I

Special Construction Materials, Building Equipment and Supplies

Hospital floors probably caused much worry to the ancients, since otherwise so many intricate problems could not have been handed down through generations to those of us who are still seeking something like a unanimity of opinion. The exposition offered much assistance to the individuals interested in flooring problems.

A new idea in battleship linoleum is a special border in any color desired which relieves the monotony of the solid colors in much the same way that hardwood floors are sometimes treated in the interests of esthetic effects.

A rubber stair tread and nosing for covering any plan of stairway was shown.

A rubber tiling which aroused much interest was one with interlocking flaps on four sides so that each flap is placed beneath the adjoining tile and cemented, absolutely preventing it from rising. Holes are also provided within the flaps so that the tile may be nailed down to wood or cinder cement.

In one of the booths there was shown an interesting cove base made of reinforced rubber which is obtainable in various colors.

The rubber floorings reinforced with cotton fabric attracted considerable attention, and in one booth there was demonstrated what can be done in decorative designs through the use of inlays of different colors. A particularly interesting feature was the conventional and nursery designs recommended especially for rest rooms, solaria, and children's hospitals.

Linoleum floors in moiré and imitation marble effects in new weights and various designs were exhibited.

Only one mastic flooring was shown and this was recommended by the manufacturer only for service rooms and corridors, kitchens, power plants, laundries, morgues and garages, as being economical, permanent, water-proof and relatively softer than concrete.

An interlocking paving block of rubber designed to insure quietness in courts, alleyways and possibly in the streets adjacent to hospitals represents a long step in the effort of achieving zones of quiet.

The display of plumbing equipment included additions and standard items. One of the special features was the toilet units, for private and semi-private rooms.

One of these consisted of a syphon jet water closet with detachable seat, provision being made to support this seat on rear partition wall, thereby converting the toilet into a clinic sink in which bed pans may be emptied and flushed by means of a jet in the bowl by turning the

*This comment on the exposition was written by one of the editors of THE MODERN HOSPITAL whose professional work includes the administration of a group of hospitals; and who as a consultant is responsible for the planning, building, equipment and organization of a considerable number of new hospitals during each year.

**See article for the six natural divisions of hospital purchasing in the March, 1923, issue of THE MODERN HOSPITAL, p. 280; also see pages 67-68 of the convention supplement, October issue of THE MODERN HOSPITAL.

hot or cold water wall valve at the right side of the operator. On the left side is provided a utensil rack supported on the wall for bed pan and urinal.

Another combination water closet and bed pan sink had integral lugs in the bowl for holding the bed pan in upright position, combination hot and cold water valves with long flexible armored hose provided with rose spray, so that bed pan could be washed in full view without being handled.

A device of interest was a special fixture 25x14 supported on wall bracket with sink eight inches in diameter, the entire surface being of vitreous china, which could be used in the nurses' medicine closet.

A thermostatic control on the knee action valve of a surgeon's sink was demonstrated. It consists of a special lever for adjusting any desired temperature, after which the action valve regulates the volume of water furnished at the desired temperature.

A new idea was a plaster intercepting trap, consisting of a number of copper gauze baffle plates, which is an adaptation of a similar device on the market for intercepting grease.

There was also displayed a baby bath with slab which was heated by means of a circulating steam coil, thereby preventing the chilling of infants.

A sound deadening treatment for walls and ceilings of hospital rooms and corridors made of accoustical felt covered with special membrane was demonstrated in a miniature room built in the exposition hall.

Several improvements were shown in ambulance service, such as the inclusion of hot and cold running water, cabinets for pulmotor or lungmotor, bed pan and urinal, and enameled basin. An ice box and drinking cup dispenser were also provided, and a rack included for baby basket.

A new lighting fixture recommended for rooms and wards was shown in a specially built dark room for the demonstration of two intensities of light; one for full illumination, but with the element of eyestrain eliminated, the other as a night light.

In another part of Mechanics Hall there was exhibited a very complete line of lighting equipment especially designed to meet hospital requirements.

A new incinerator and hot water heater made of cast iron, lined with crushed fire brick, that can be installed readily by hospital employees furnishes an article much needed in many hospitals.

The progress in the adaptation of nickle to the various parts of the hospital and to various types of equipment was shown in a booth devoted to monel metal.

A call system applying the idea now in use in legislative voting, whereby the patient registers his needs at the nurses' station was of particular interest. A silent call system for nurses had the following interesting features: non-breakable aluminum button, washable flexible cord and flashing system, easy replacement of signal lamps in dome corridor stations, and no working parts concealed within the walls.

A new adjustable shade was shown which permits of cross ventilation and free passage of air through lowering upper window sash. The principle of this is carried out by means of upper and lower shade rollers, the upper being fixed, sliding on two vertical metal guides which are operated from the top roller by reinforced brass strips.

Some interesting items in hospital hardware were displayed, one item being a combination door pull with upper hook for opening doors by wrist or arm, thus eliminating contact with hands when desired. Another was a noiseless lock operated by spring friction instead

Another view of exposition hall showing the many exhibits of equipment and supplies.

of a latch. Also there was demonstrated a rubber inset cushion placed in the door frame to eliminate noise when closing the door.

SECTION II

Hospital Furnishings and Supplies

The exhibition of beds and bed room furniture in metal were of special interest and indicated the noteworthy advances made recently in these two lines.

A novel feature of an adjustable bed is two coiled springs placed on either side of the frame and operated by a cranking device, the purpose being to assist in elevating the head rest and thereby reducing the wear on the adjustable parts.

A metal pipe bar half or full length for patients' and children's beds to prevent them from falling out of bed was also shown.

A simple friction locking device operated at both ends and requiring that both ends be released before the sides can be raised or lowered fills a need on children's beds where the nurse is troubled with children lowering the sides.

A new hospital bed caster was also displayed, which embodied two novel improvements:—a socket which can be driven into any size bed post, the caster pin, being pointed, bears on a flat surface in the socket which is machined. The wheel consists of two plates which hold the tire in place. An advantage here is that the tire can be replaced; also the brass bushing may be renewed, if necessary, the latter accomplished by the removal of but two nuts.

An exhibit of metal bedroom furniture, including dressers, bedside tables, somno, chairs, rockers, made in various colors was of particular interest.

A water-proof covering for mattresses, cushions, of sheeting water-proofed by a patent oil process, tends to well fill a most desired need that will appeal to nurses and housekeepers.

In one of the booths there was shown a blanket of cotton warp with 100 per cent wool filler which was recommended as being more economical and efficient than the usual cotton throw blanket.

The exhibit of textiles was one of the most complete in the exposition. Nearly all of the prominent houses serving the hospital field were represented.

A soap and water mixer for general use in which any proportion of soap and water can be obtained was demonstrated. It was interesting to know that hospital green soap can be used in this mixer.

A very interesting feature in linen substitutes was the inclusion of embossed monograms, insignia or names, the result of which was extremely attractive, when combined with the blind embossing which gave the appearance of a hemstitched border. Tray covers with nursery rhymes attractively colored for children's trays were also of interest.

A metal bed cabinet which provides a monel metal tray sliding out from upper compartment was also displayed. The tray of this cabinet may be converted into a writing table adjustable to any angle. Below the tray there were compartments for wash basin, drawer for personal effects, and space provided for a bed pan and two urinals.

An interesting device was shown in a combination chair and bedside table swinging on the transverse upper connecting rod on the back of the chair, and when not in use hanging against the back of same. A metal bedside table and cabinet was shown on which the wash basin was attached to swinging door, beneath which there was a sanitary drawer, and under this a compartment with room for bed pan and two urinals.

NOTE:—Additional new features will be described in the December issue.

A perspective of the exhibits of exposition hall as one approaches from the main entrance of the auditorium.

REPORTS OF COMMITTEES

REPORT OF THE BOARD OF TRUSTEES

SINCE the last report to the association, your trustees have held five meetings. Two of these were held in Atlantic City during the Twenty-fourth Annual Conference in order to transact the growing amount of business incident to the annual meeting. The others were in the office of the association. The development of the association has required of the board of trustees correspondingly increased activity and increased responsibilities. With an annual budget approximating $50,000 a year there are many questions requiring decision by the responsible board.

Many of the acts and decisions of the trustees are necessarily concerned with the routine work of the association—authorizing specific procedures and policies for the guidance and support of the officers, and, although important to this end, need not be mentioned in this report. There are, however, other decisions and acts which should be reported for the information of the members of the association and their delegates.

Increase Membership Dues

The associate personal membership dues were increased from $2.00 to $3.00 for the reason that the sum of $2.00 no longer paid for the printed matter sent routinely to these members. It seemed proper that all members pay at least the firm cost of maintaining their memberships.

The trustees have authorized several new committees. The authorization of each was preceded by consideration of the need of the probable results of such a committee and also by the formulation of plans for the activity of this committee. It is the opinion of your trustees that the association should continue to appoint and maintain special committees as rapidly as the need for these committees and the proper support—financial and otherwise ——for each is developed.

In recognition of the valuable services rendered to the members of the association and to the hospital field by the Hospital Library and Service Bureau, the annual appropriation from the association to this Library was increased from $1,000 to $2,000. This figure was determined, not by what was regarded as the value of the service of this library to the hospital field, but rather by the limited income of the association.

The plan of the National League of Nursing Education for the classification of nursing schools was officially presented to the trustees. The following resolution was adopted:

Resolved, that the trustees of the American Hospital Association do hereby express approval of the general plan that schools of nursing be classified by a properly qualified and authorized committee representative of all interests involved, and at the proper time will officially cooperate through the appointment of suitable persons to represent the association and the interests of hospitals on this committee.

An official delegate from the American Hospital Association to the Octo-centenary of St. Bartholomew's Hospital, London, was authorized and the selection of this delegate placed in the hands of the president. Dr. S. S. Goldwater was appointed and was present at this celebration.

The board reluctantly accepted the resignation of Miss Mary M. Riddle as a trustee of the association, but the reasons advanced by Miss Riddle were considered to be sufficient and valid. Miss Margaret Rogers was appointed to fill out the term of Miss Riddle, which expires with the present conference.

Investigate Exhibiting Firms

It is the desire and intention of the trustees to protect all hospitals as well as the members and delegates here assembled from unwise and unsatisfactory business dealings. As contributing to this the careful investigation of all firms permitted to exhibit at the conference was ordered and the following resolution, quite similar to the corresponding resolution of last year, was adopted:

Resolved, that the executive secretary be and hereby is authorized and instructed, whenever so requested by any hospital, to undertake the settlement and adjustment of any question arising from the purchase during the conference of any article from any exhibitor at the 1923 conference of the association and to act likewise for any institutional member regarding any purchase from any exhibitor at this conference made during the period between the 1923 and 1924 conferences, the object being to assure to hospitals, and particularly to institutional members, satisfactorily results from dealing with those who are permitted to exhibit at the association meetings.

Realizing that properly trained and prepared executives will be the most important factor in the future development of the hospital field and in order to secure the full benefit from the recent study of this subject the trustees authorized a committee to be known as the committee on the training of the hospital executive. This committee is instructed to develop public opinion, ways and means and a definite practical plan for the making of a beginning in the systematic training of the hospital executive.

The question of an official insignia for the association was again brought before the trustees and discussed. All agreed as to the value and need for an insignia for the association which would also designate hospital service generally but no design submitted was approved. The president and executive secretary were made a committee to study the problem farther and any and all expressions of opinion or suggestions will be gratefully received by them.

The question of the giving out and the publication of facts and statistics concerning institutional members collected by the association was brought before the trustees. The decision of the trustees was to authorize the executive secretary to publish or otherwise announce the names of the hospitals from whom specific items of statistical information have been obtained for the association, provided that no objection thereto has been expressed by the hospitals and provided also that the use of the name of the institution will add to the value of the figures for the purpose desired. This is called to your attention, first, that you may understand the policy to be followed, and second, that any information provided the office of the association which hospitals do not desire to be announced or published in connection with their names may be protected by accompanying the information with the request to withhold the name.

The receipt of a number of letters from hospitals in foreign—especially South and Central American countries—inquiring as to the work of the association and expressing a desire for our literature, interested the trustees. It was recommended to the constitution and rules committee that an amendment to the constitution be

drafted providing for a special form of institutional membership to meet the needs of these hospitals.

Member of Fire Protection Association

Within the year the membership of the American Hospital Association in the National Fire Protection Association was established.

The present plan of collecting the annual dues of personal members through and by the geographical sections is clearly not successful. No member from one geographical section was entitled under the by-laws to vote at the conference last year. No dues at all from this state had been paid.

The sections now average fifty per cent more members in arrears than the average of the states paying direct. This situation must not exist. The officers of each of the sections will meet with the trustees during this conference for the purpose of working out a better arrangement.

It is the opinion of your trustees that the association made distinct progress in the past year. We are closing the year larger, stronger and with the record of more work both under way and accomplished.

REPORT OF THE EXECUTIVE SECRETARY

Your executive secretary is pleased to report that the past year has been one of marked progress. Of this conference, its program and accomplished plans, you will judge for yourselves. The address of your president has outlined the milestones in the development of the association up to this time, and also some of the existing opportunities for future progress. The report of the trustees has related the basic decisions of the board during the year. The reports of the treasurer and membership committee will present the progress of the year in figures. But these reports do not tell all the story. There is more. In the past year the name of the American Hospital Association and the address of 22 East Ontario street has become known to many more, and more favorably known than heretofore. There is ample evidence of this in the greatly increased volume of correspondence from persons and organizations outside of our membership, There is evidence of this in the many more letters received asking of us specific information concerning the hospital field and in the increased number of visitors at the office seeking information, assistance or technical advice. There were throughout the year many other indications that the association was making distinct progress toward the position it should hold generally and in the development of the functions within the field it should have.

There was in the year more progress made in the further development of policies already inaugurated than in developing new policies, and the results have indicated the wisdom of this. The association is in organization and policies practically the same as last year but grown larger, stronger, and better in every activity.

Committees

The practical distinctions between the "standing" and the "special" committees have almost disappeared. The special committees stand from year to year until their work is done and the standing committees take on special problems. This has come directly from the efforts of the committees of both types to produce and report definite information and material of maximum value. The idea of thorough investigation of special problems carried on by the association through committees has long been established, but, unfortunately, has been and yet is curtailed by lack of funds.

A most valuable idea supplementing the idea of the technical special committee has spontaneously appeared and has gradually come into prominence, appearing first in the out-patient committee. This calls for the appointment and interprets the function of various committees as a means of carrying on for the association a continuous study of and a watchfulness over special problems or subjects active in the hospital field and the reporting from year to year to the association of the important changes, events and developments in these problems or subjects. Combined with this is the idea that these committees should officially represent the association in all the activities in and of these problems, keeping a constant watchfulness over them and exerting a helpful influence whenever possible. Cooperation of the association with other organizations through these committees is also assumed. Many of our committees are now approaching this type.

Our committee program and organization is all important for therein lies the basic producing power of the association and this must grow with every year. This organization must be carefully studied, directed and supported to the limit.

As the committees increase in number with the corresponding increase in personnel, the problem of correlating their activities each with the others, and of providing the personnel with official information and the routine assistance of the home office will appear and in fact has appeared. The volume of work involved in the proper support of the committees by the home office is great. This is one of the problems now demanding solution by your trustees and executive secretary. It is a matter of increasing and expanding the work of the home office.

Membership Records

The fact that this meeting would be the twenty-fifth annual conference of the association sharply emphasized the value of the membership records, also the necessity for getting them into permanent form.

An effort to compile a table of the totals of the annual membership rolls as published in the annual proceedings and of the attendance at the past annual conference called attention to discrepancies and omissions in the published figures. To get and to check many of these figures it was necessary to actually count the members appearing on the records for these years. The published figures were not sufficient. Some of these records were missing and were not readily located. We are, however, now pleased to report that all the old records have been found and filed in the office of the association. All the missing figures have been determined and checked. The table which has heretofore been published several times in incomplete form appeared complete and correct in the *News Bulletin* of this morning.

We wish to announce also that in the printed proceedings of this conference the membership roll will show the year in which each became a member of the association. This item of record is now complete.

The proper protection of the records of the association was studied, for it was recognized that a loss by fire or otherwise would prove a real disaster. An approved and standard fireproof safe of ample size was purchased and installed and all original and essential records are now kept therein. Details in the form and methods of keeping the records were adjusted to the constant use of the safe repository. For the first time, the records at the registration desk are duplicates, thus avoiding risks from transportation. The originals are in the

fireproof safe at the home office of the association. The association has celebrated the twenty-fifth anniversary of its founding by getting the complete—not merely current—membership records in better, and, we believe proper condition, and by giving to them adequate protection. This has been accomplished only by the expenditure of time, effort and a considerable amount of money, all of which were necessarily diverted from other activities; but we believed the association would approve.

Publish Subject Index

This year also seemed the proper time to publish a comprehensive subject index of the literature on hospital construction, administration and operation as brought out by the twenty-fifth annual conferences of the association. This literature is the most valuable on these subjects existing and is not properly used nor appreciated because of the lack of a subject index to make it readily available for reference. The work of preparing such an index was begun with the publication of the proceedings of the twenty-fourth annual conference and has continued throughout the year. A few of the individual volumes were adequately subject indexed, but many contained only lists of the titles of the papers. It was necessary to read all this material and write a subject index for each of these volumes before the combining of all into one index. This combined subject index for the twenty-five years will be published with the proceedings of this conference.

Office Activities

The foregoing activities did not take up all the time and attention of the office. Sixteen hundred dollars were expended for postage—exclusive of the cost of mailing the proceedings—which sum purchased 88,000 two-cent stamps. This means an average of sixteen communications for every hospital of twenty-five or more beds in the United States and Canada. Fifty-three thousand letterheads were used by the secretary's office alone—an average of over ten letters for every hospital of twenty-five or more beds in Canada and the United States. This does not include the identical letterheads printed as a part of circular matter.

Ten thousand copies of *News Bulletin No. 3*, which was devoted entirely to stating the preliminary program and plans for this conference, were placed in the field. Three thousand copies of any communication are now required for both the institutional and personal members and the few organizations on the mailing list.

The mechanical work of getting out these many letters, bulletins and other communications, even after the manuscript thereof is prepared, is heavy and the cost correspondingly large. This is, however, one of the essential activities of the association. All of the dues of the associate and the greater part of the dues of active personal members are returned directly through first cost of the proceedings, bulletins and essential communications sent each member. But this is as it should be.

The routine work of the office practically doubled in the past year, requiring that the office force be correspondingly increased and many articles of equipment purchased.

Standardization of All Publications

The size and form of the various publications and bulletins of the association has varied much. There has been no established policy. The increase in the number of these publications made it advisable to adopt a uniform size to facilitate filing. The proceedings of last year were published in the larger size of type and paper page used in the earlier numbers but a thinner paper was used to reduce bulk. All recent technical bulletins have been published in this size. With No. 3 of this year the quarterly *News Bulletin* adopted this same size. This leaves only the *Daily Bulletin* of the annual conference to be published in an odd size. If this standard size proves satisfactory to the association, it will continue to be used, as it has many advantages.

The Exposition

The exposition in the form attained and with all accomplished plans is before you. Judge it for yourself. But it is proper that you should know that the officers of the Exhibitors' Association have worked hard to make this exposition what it is. They assumed responsibility for the development of the model kitchen. Through their efforts definite policies have been established. It is agreed that there shall be no pressing for sales and that any booth may be visited by any delegate without any thought of purchase or commitment. There has been careful study and planning to make every booth present a maximum of interest and educational value—and not to be merely a market place.

The sincere acceptance of this policy is reflected in the personnel present with the exhibits. The sales managers of many—probably a majority—of the companies have taken advantage of this opportunity to discuss their products critically and directly with the users thereof in the hospital field, and are present. With most of the exhibits of mechanical equipment, technical experts have been sent to discuss the practical requirements and to give expert service to those using their equipment or desiring information. These men can give you technical information and practical suggestions far better than you can ordinarily secure. They are the factory experts.

Membership in the Association

The membership in the association is growing steadily but to your executive secretary the rate seems too slow. Every activity, every publication, brings as a direct result a few more members. A service rendered often ends in established membership and a few members are secured directly by correspondence from the office. This year there has been one most welcome change. We have received a considerable number of voluntary inquiries as to institutional membership from hospitals widely scattered and without a direct cause for the communication becoming apparent. Most of these inquiries have resulted in established membership. Several of these inquiries were from countries other than Canada and the United States and it was these that led the trustees to suggest changes in the constitution which would make these hospitals eligible to special form of institutional membership.

But how long must it be before the hospitals of Canada and the United States recognize generally that the American Hospital Association is simply an association of themselves and for themselves; recognize that it is merely the usual form of organization of the individual plants of an industry and their operating personnel into an effective central bureau of service and information based on common effort and the prompt exchange of ideas for the benefit; recognize that their individual and pressing problems are all common problems varying in other hospitals only in degree and that a common study can help all alike with the cost thereof distributed? When will all realize that participation in the common support of the association can bring to them—at a price within their

reach and with their full share of the cost paid—service, studies, concrete facts and figures and the thoughtful opinions of many, such as the individual hospital could never secure? When will the direct value of these conferences to hospitals be generally recognized and the attendance correspond therewith?

Other kinds of plants and industries—far simpler in every way and with fewer problems—have learned all this. These seem to accept the fact that the same personnel brought to common contact through a central bureau or association will produce far more than when working as scattered units, and at a fraction of the cost. Perhaps a man or woman working or thinking in isolation without contact with or comments from other workers could produce as much as when working with others, but they won't. The stimulation from contentions, comparisons and competition is lacking.

Why is it that a hospital—often with inexperienced executives, such as most meager salaries can secure—is so likely to drift into a policy of local isolation and will attempt to meet all their technical problems with their own scant resources? These hospitals laboriously work out or work at problems that some one has already satisfactorily solved with a method now much used, but unheard of to them. Why is it that some trustees will expect their superintendent to keep up to date and informed concerning the detail of hospital operation without providing the small sums required for membership and participation of the hospital in the association and its activities, or for traveling expenses to attend meetings of any kind, or even for a magazine subscription? Of course, they don't have—or at any rate, don't long keep—an up-to-date superintendent, or have executive decisions based on knowledge common in the hospital field, but they seem to think they do. Hospital superintendents are human with human limitations and the proper administration of a hospital with its intricate relations to the medical, nursing and public health, social and economic fields, can not come through intuition. It is a highly technical job.

It is true that hospitals are even yet often interpreted as a local charity instead of an institution to provide expert technical service and an essential industry. But can this now, or could this ever, have justified local isolation and ignorance of the work and progress in other hospitals? Every hospital must answer these and similar questions for itself, and their attitude thereto is made known through their operating efficiency and resulting service to patients.

ALBERTA HOSPITALS ASSOCIATION MEETS

The annual meeting of Alberta Hospitals Association opened in Calgary, Thursday, September 5, with representatives from Calgary, Holy Cross, and General Hospitals, McLeod, Lethbridge, High River, Drumheller, Medicine Hat, Red Deer, Edmonton Misericordia, General and Royal Alexandra Hospitals.

Several interesting papers were read at the meeting. Mr. Norman McLean spoke on the problems and achievements of the municipal hospital. A most instructive paper prepared by Mr. A. W. Edwards, manager of the Palliser Hotel, was read by the secretary. Mr. Edwards spoke of the psychological effect of subdued tints on the inmates of a room and suggested pictures in wards and rooms, especially in children's wards. Dr. Washburn of Edmonton gave his personal impressions of hospital management as seen on his recent trip to Eastern Canada and the United States.

Dr. Archer spoke on "What We Like Best and Require Most from the Doctor" (the hospital's viewpoint), care and attention in keeping of records was stressed. Dr. Lincoln spoke on "What We Like Best and Require Most from the Hospital (a doctor's viewpoint). He stressed cooperation and a faithful carrying out of orders. Dr. Dunlop gave a careful resume of the advance of medical science and Dr. Collisson of Red Deer spoke of a doctor's usefulness as a physician and as a citizen in a community, speaking from a long experience in a rural district.

The four resolutions forwarded by the Edmonton Hospital board, viz.: (a) home for aged persons and incurables; (b) government help for hospital training schools; (c) government grants towards free treatment of children suffering from bone disease or deformities; (d) change in existing legislation with regard to collection of accounts; were endorsed by the provincial meeting and turned over to the special legislation committee which was instructed to bring these and others to the attention of the provincial government at the earliest opportune time.

Mr. Christie, of the Ontario Laundry, gave a splendid talk upon laundries and said it was his opinion that the great leakage in Hospital Laundries was due to the lack of cooperation between the nursing staff and the laundry staff.

Mrs. de Stage, of the Holy Cross Hospital, gave a detailed account of the Record System as used in the Holy Cross Hospital and showed how easily a threefold record of each case admitted to the hospital might be kept, viz.: (a) The patient's personal record; (b) A record of the disease itself; (c) A record of a doctor's patients.

This paper occasioned a great deal of discussion, and dissatisfaction was expressed with the system adopted by the government in obtaining records from hospitals.

Officers elected for 1923-24 are: Honorary-president, Honorable R. G. Reid; president, Dr. H. R. Smith, Edmonton; vice-president, E. E. Dutton, Esq., Lethbridge; and secretary-treasurer, S. V. Davis, Edmonton. The executive committee consists of Father Cameron, Calgary; Dr. Washburn, Edmonton; E. W. Starkey, Esq., McLeod; H. B. Stickney, Esq., Morrin.

The following were asked to act upon the Special Legislation Committee: Dr. H. R. Smith, Dr. A. E. Archer, W. T. Henry, Esq., and E. E. Dutton, Esq.

Friday noon the delegates were entertained at luncheon at Bowness Sanitarium and after luncheon a visit was paid to the various units and a very interesting symposium was given by Dr. L. S. MacKid, Calgary, and Dr. A. H. Baker, superintendent of the sanatarium.

INDIANA HOSPITAL ASSOCIATION COMMITTEES FOR 1923-24

The Indiana Hospital Association has chosen the following committees to take charge of its divisions for the year 1923-24:

MEMBERSHIP

C. A. Naffe, M.D., superintendent, Indianapolis City Hospital, Indianapolis, chairman.
Miss Edith Willis, superintendent, Good Samaritan Hospital, Vincennes.
W. M. Reser, M.D., secretary, executive committee, St. Elizabeth's Hospital, LaFayette.

LEGISLATION

George F. Keiper, M.D., LaFayette, chairman.
Chas. N. Combs, M.D., superintendent, Union Hospital, Terre Haute.
H. A. Deumling, Lutheran Hospital, Fort Wayne.
Miss Elizabeth Springer, superintendent, Huntington County Hospital, Huntington.
Miss Myrtle E. Elkins, superintendent, Miami County Hospital, Peru.

AUDITING

Miss Ida McCaslin, secretary, State Board Examiner, Lebanon, chairman.
Miss Mary E. MacDonald, superintendent, Elkhart General Hospital, Elkhart.
Miss L. L. Goeppinger, Deaconess Hospital, Fort Wayne.

CONSTITUTION AND RULES

M. F. Steele, M.D., Hope Methodist Hospital, Fort Wayne, chairman.
W. O. Gross, M.D., Lutheran Hospital, Fort Wayne.
R. B. Wetherill, M.D., St. Elizabeth's Hospital, LaFayette.

HOW TO TEACH THE VALUE OF SUPPLIES AND EQUIPMENT TO THE HOSPITAL PERSONNEL*

By CHARLES SIDNEY PITCHER, Superintendent, Presbyterian Hospital, Philadelphia, Pa.

THE BEST way to prepare to teach the value of supplies and equipment is:

(1) By learning the value of supplies and equipment oneself.

(2) By setting a good example in the use of supplies and equipment.

(3) By selecting a personnel which is teachable.

(4) By reiteration and demonstration without irritation.

(5) Conclusion.

No. 1

A rapid and accurate method of learning the value of supplies and equipment is to examine the expenditures for operating the hospital. The expenditures will vary from year to year but a good insight may be obtained through the consideration of the cost of each department in its relation to the total expenditures for all departments.

The following is an illustration of the expenditures for all the departments of a hospital:—

	Per annum
Administration	1.58%
Professional care of patients	5.30%
Pharmacy	1.79%
Pathological laboratory	0.68%
X-ray department	0.79%
Out-patient department	0.64%
Training school	0.41%
Housekeeping	4.51%
Provisions	24.51%
Laundry	0.80%
Power plant (heating and lighting)	6.26%
General house and property (including repairs)	15.25%
Ambulance	0.78%
Social service department	0.22%
	63.39%

In this set-up the regular salaries and wages are 36.61% which figure does not include payments for extra labor amounting to 5.09%, that were made for repairs under the classification "General House and Property".

The expenditures for regular salaries and wages usually average from 40% to 50% and sometimes more. I have noticed in examining the annual expenditures of general hospitals that hospitals having high salary and wage expenditures frequently have a corresponding low cost for supplies. This would indicate that it is economical to employ capable people at a fair rate of pay.

A study of the set-up shows that the largest expenditures were for:—

	Per annum
Provisions	24.51%
General house and property (including repairs)	15.12%
Power plant (heating and lighting)	6.26%
Professional care of patients	5.30%
Housekeeping	4.51%

Provisions, the greatest expenditure of all, are usually handled by the lowest paid and least experienced of the personnel; beginning with a low-paid, inexperienced storeroom force, followed by a low-paid, inexperienced kitchen group and ending by being served, to a large extent, by inexperienced and untrained ward maids, and pupil nurses. Under these conditions should we wonder why the provisions are slaughtered and wasted? Supplies and equipment used for general house and property purposes, if placed in the hands of an underpaid, and untaught personnel meet the same fate as the provisions.

These two classifications (provisions and general house and property—including repairs—) alone cover nearly forty per cent of the expenditures of a hospital.

All other supplies and equipment are liable to the same destruction and waste when handled by an untaught personnel.

No. 2

Superintendents and heads of departments should set a good example in their personal use of supplies and equipment. They should not be like the preacher, who, on being taken to task by his good wife for not practicing in his every day life what he preached in the pulpit, replied: "Why mother! How can I do this? I have to preach for the whole community."

Superintendents, medical directors, directors and all the other dignitaries and executives of a hospital community should be shining examples for the other members of the community to follow in the careful, economical, and proper use of supplies and equipment.

No. 3

Advice is said to be something everyone is willing to give but no one is willing to take. In selecting our personnel we should try to secure those who are willing to take advice, in other words, persons who are teachable.

During the World War, Spanish-American War and at other times when the public mind has been overwrought, those of us who can recall these times will also recall that newspaper writers and cartoonists poked fun at what they termed "home strategy boards" usually depicting a group of farmers gathered around a stove in a country store chewing or smoking tobacco and expectorating at a box of sawdust, while they engaged in the indoor sport of discussing how a certain battle should have been fought or, in general, how to run the government.

Don't think for one instant that the "home strategy board" is only found in country districts, for it is active in clubs, hospitals, and all places where two or more are gathered together. Each group of hospital workers usually has one or more of these "home strategy boards" who are certain in their own minds that they know more than the trustees, superintendent, or anyone else, how the institution should be conducted. In certain instances, no doubt, they may be correct in their opinion. No one has a corner on brains and everyone who has brains enough to be worth mentioning will think about something. Our job is to select a personnel who will use their brains to think about right things.

Please consider carefully what a force for good will be set at work by directing the minds of these "home strategy boards" in right channels of thought, through posters, hospital publications, and other literature bearing on their work. It is highly desirable to give the personnel a proper perspective of the duty they owe the hospital and the duty which the hospital should fulfil to the public it was created to serve.

*Exeerpt from the paper read by Mr. Pitcher at the evening session, Tuesday, October 30, of the twenty-fifth annual conference of the American Hospital Association held at Milwaukee, Wis., October 29, to November 3, 1923.

No. 4

* * * * If you are capable and have the time, teach the personnel yourself, if you are not, secure the services of those who have the experience and knowledge; and who have the ability and desire to teach others.

The United States Food Administration demonstrated the possibility of teaching large groups of persons to save without detriment to individual or public health.

Thrift campaigns demonstrate this fact.

The use of inspirational posters, mottoes and instructive reading matter is largely made to develop a proper frame of mind in the public as well as the services of public speakers. We are all familiar with the posters and publications of the food administration which saved such vast quantities of wheat, meat, fat and sugar for war purposes. "The more we save over here the more we serve 'over there'" was one of the telling slogans. This slogan was to inspire us to save to win the war. We can employ the same idea in teaching the hospital personnel the value of supplies and equipment.

How did the food administration find out what would have the strongest appeal to the public? The method employed was both direct and simple. A conference was called of the different groups representing the food administration, what it was desired to accomplish was freely discussed, committees were appointed and everyone went to work with the understanding that they would report to the conference at a given hour on a certain date. When this time arrived the conferees assembled and the work of the committees was considered.

The representative of the advertising section would present posters. The most effective poster for a certain purpose was determined by a majority vote of the conferees. Circulars of information and inspirational literature were selected in the same manner. Some may think this was all right for the food administration, but can the plan be applied to a hospital?

Let us consider this phase of the matter.

The rank and file of a hospital are usually well meaning, honest, but inexperienced persons.

The majority of a hospital personnel in order to secure promotion, is willing to become proficient in their work. Few persons think of the things in daily use in their relation to dollars and cents. Persons to be thrifty must be taught thrift, the same as to eat or walk. Saving is a state of mind and a person to save must have some reason which gives him the impulse to save.

In individual saving which, in a hospital, results in group saving, there must be one central object to impel the group to save. More can be accomplished through creating the desire to save and directing this desire in proper channels, than by arbitrarily reducing the requisitions for supplies and equipment without just warrant for so doing.

An arbitrary cutting down of requisitions for supplies, without a sufficient study of the needs of an institution and the proper training of the persons using the supplies, is liable to result in deprivation. It is dangerous to arbitrarily reduce requisitions unless the hospital, after careful study, has established standards for the use of supplies, that is, lists giving the maximum of the different articles that will be furnished for a certain number of persons. These issuing lists or standards may be established through the experience at the hospital, combined with the experience of other hospitals.

How we use supplies is more important than how we purchase them. You may have the most refined and well worked-out system of buying to save the last penny possible in this direction, but the institution may still be wasteful and lax in the use of things.

The amount saved by the most efficient purchasing system, when compared with the average purchasing conditions will not exceed five to ten per cent, while a proper regulation of the use of supplies may easily secure a saving of from fifteen to thirty per cent.

The saving effected through the regulation of the use of supplies has been very marked where careful attention has been given to the matter.

If we can impress upon our hospital personnel this idea of making things last longer, making supplies go further, and general carefulness in the use of hospital property, we will have gone a long way in solving the high cost of operating a hospital.

In 1921 we conceived the idea of a thrift poster to promote economies in our hospital. This thrift poster has received considerable publicity and notice. * * * Two hospitals have requested permission to utilize the reading matter of this poster in thrift campaigns which they instituted. Several hospitals have requested that copies of the poster be mailed to them and the Department of Welfare of Pennsylvania utilized the poster in its suggestions for economy in the state-owned institutions. The poster has created so much interest that I venture to describe it at some length. The purpose of the poster is to impress persons with the idea to save money not simply for the sake of saving money but so that the money saved may be used in the construction of new buildings, which is the objective of the board of trustees, the medical staff, the superintendent and all other persons connected with the hospital.

The poster was prepared by the superintendent, assisted by members of the board of trustees, medical staff, ladies' aid society, the directress of nurses, the housekeeper, the chief engineer, and other heads of departments. The poster represents the thought and experience of many persons.

To emphasize the idea of saving and how savings may be accomplished, the poster was placed in frames about the institution, preferably beside telephones or other places where one is liable to wait, and would, therefore, have time to read the poster. It was also distributed to all persons on the pay roll at the time of receiving their pay and extra copies were supplied heads of departments for distribution to new employees. The poster was placed in frames which had been used for discontinued notices, to emphasize the idea of making use of things which were already on hand.

The main idea of the poster is to get everyone headed in the same direction, i. e.—to save money to construct the new hospital buildings.

The poster is sixteen inches wide and twelve inches high. It is divided into two sections, left and right. "Save Money to Construct the New Hospital Buildings" is printed in bold type at the top of the left half, which contains the following twenty-six suggestions for economy:—

1. Cordial co-operation in and between departments is essential.
2. Physicians, chiefs, assistants and residents, as well as nurses and employees, are requested to bring about the economic use of drugs, dressings, appliances and surgical supplies, as well as all food supplies.
3. Do not use an appliance or a surgical instrument, except for the purpose for which it is intended.
4. Save the worn-out article or the broken, in order to obtain a new one on requisition.
5. It is sometimes alleged hospitals are wasteful and extravagant. Help to avoid such criticism.
6. Do not light an electric lamp or gas when not necessary. To do otherwise is wasting money. If you find an unnecessary light burning, turn it off. All lights not actually needed should be extinguished by 9 p. m.
7. Do not fill ice-water pitchers full of ice. Use ⅓ ice and ⅔ water. A very large saving in money will result from this practice.
8. Keep ice chest and refrigerator doors closed.
9. Turn off hot and cold water faucets. Water costs money.
10. Turn off steam from radiators, when heat is not needed. This will save coal.

11. Blank forms cost money. Do not use them for purposes for which they were not intended.
12. Old rubber is valuable. Do not throw any away. Keep rubber in cool place. Do not allow any form of grease on rubber, as it causes it to rot.
13. When you have time, do not take the elevator to go up or down one or two flights of stairs.
14. Kindly cooperate in the economical use of linen.
15. China is very expensive. Observe the utmost care in handling.
16. Lack of care in the use of food supplies wastes money. Order only what is needed, and return all unserved food to the kitchen.
17. Before making requisitions, assure yourself that it is **absolutely** necessary.
18. Each ward or department should keep an accurate account of all supplies.
19. Supplies are not to be taken from the hospital.
20. Physicians, nurses and others are requested to practice the utmost economy in the use of gauze, cotton, bandages, etc.
21. Loss of time is wasteful and extravagant. For instance: Tardiness at duty often causes confusion and dissatisfaction. Tardiness at meals not only means delay in going on duty, but extra work in the dietary service and in other departments.
22. Handle all hospital property and equipment with the same care you would if you had paid for them with your own money. Our repair bills are enormous.
23. Request for repairs should be made by the head of the department on blanks provided for that purpose and sent to the superintendent's office.
24. When we all unite in small economies, it will produce a large economy for the hospital as a whole.
25. The use we make of our present facilities will, to a large extent, determine how soon we can construct the new buildings.
26. The hospital has been carefully operated in the past. Let us emulate our predecessors in keeping our institution in the forefront of the hospital world. To do this we must be careful in our use of all material, equipment, food and other supplies.

The right half is a price list of a number of articles used by the hospital grouped under various classifications. "Save! So the Hospital May Go Forward" is printed in large type at the bottom of this half.

Some of the pleasing results of the poster are constantly evidenced. Some of the personnel are suggesting how to save, others are telling how they are saving in their work. A statement of one of the colored orderlies to the superintendent a few days after the poster was distributed, while he was watching him fill an ice chest is a fair example of the reaction caused by the use of the poster; "I shur don't fill dis ice chest full any mo' so de cover don't shut." He was thinking of suggestion No. 8 of the poster—"Keep Ice chest and refrigerator doors closed."

It is noticed that heads of departments, in making requests for equipment or changes in construction, more frequently present the matter from the standpoint of effecting an economy than formerly. That is, the improvement will ultimately produce a saving of money. To illustrate, one head of a department recommended a certain change and stated that through the change economy would be effected in a certain direction in which the hospital was wasteful.

When we consider how long it is possible for equipment to last, one has but to recall that his or her mother has a sugar box or a tea canister or other things which have been in use since one is able to remember, even though he is now in middle life. I have seen old-time household utensils on exhibition in a museum of which duplicates of equal age are still in use in households of rural communities. We have a wheel chair at our institution which is entitled to special notice. The plate giving the name of the donor and other information indicates that the chair was donated to the hospital in 1900. During the past three years, the chair has been in our shop twice for slight repairs. I sometimes wonder if the chair may not be like the old lady's stockings which she said she had worn for twenty years; stating that one year she footed them and the next year she knit new legs. Whatever may be the case, the chair is in good condition and due to a recent fresh coat of paint, is as youthful in appearance as some of the younger chairs.

Blue prints or printed instructions for the care and use of equipment either placed on the equipment or framed and hung in a conspicuous place, are two of the best ways to be sure that the apparatus will be properly operated and cared for.

The burning of unnecessary electric lights is a common practice, especially when one is not paying out of his own pocket for the current used. A simple means to minimize this expensive and careless habit is to place signs on the panel boards and near the electric light switches. Small ready made signs reading "Please turn out the lights when not in use" may be purchased for fifteen cents each. These signs will save a great deal of electric current.

Similar signs will secure other economies:—

"Keep ice chest and refrigerator doors closed."

"Turn off hot and cold water faucets."

"Turn off steam from radiators when heat is not needed." (The majority of people don't do this, but open the window.)

Business firms, factories and hotels utilize signs of this nature quite extensively. Business houses use inspirational signs to encourage their personnel. Here is one I copied in a wholesale optical place manufacturing the product it sells:—"When it is finally settled that a thing is *impossible*—watch some fellow do it." This motto is from another place "Not until primitive man began to investigate did he begin to climb the ladder of fame."

The walls of many offices and public places for the sale of goods are adorned with similar mottoes. The personnel of a hospital changes so frequently that printed books of rules and instructions do not secure as good results as tersely worded signs which tell what should be done.

The personnel will read signs out of curiosity if for no other reason but they will not of their own volition read rule books.

In teaching the hospital personnel the great educational value of hospital association meetings or other meetings where groups of hospital workers are present should not be overlooked and the personnel should be encouraged to attend such gatherings.

The presentation of papers and the discussions are often of less value than the personal discussions one has an opportunity to have through conversing with other hospital workers at meetings of this kind.

One of the readiest and best means of teaching the personnel is to have the heads of departments visit other institutions. These visitations should not be hit or miss, but when one hears of certain institutions doing something worth while, it is of a decided advantage to send representatives there to learn how the results are obtained.

Some executives consider it a bad policy to furnish heads of departments with catalogues and other literature describing equipment, new devices or new products for fear that they will stimulate them to ask for equipment or supplies for which they would otherwise not think of asking. I have listened to a number of discussions pro and con concerning this subject. My belief is that heads of departments should have a complete set of catalogues pertaining to their department and should be required, when making requests, to give catalogue, and page number with specific reasons why they consider the article requisitioned the most suitable, as well as the reason for their wanting it.

We all receive letters, circulars of information and other literature describing new equipment and supplies that have been recently developed and which some enthusiastic sales manager or advertising man would lead us to believe is the best thing ever produced of its kind.

Instead of throwing these into the waste paper basket, I find it profitable to send them to the heads of departments, and if they contain information which I wish to retain in my office, to send for additional copies.

The value of this seemingly objectionable mail matter, is that in the grist of miscellaneous catalogues and circulars, are good ideas which will not appear in the regular catalogues for six months or a year.

I have not found that it caused heads of departments to ask for unnecessary articles if they were supplied with catalogues and circulars of information and other things bearing on their work.

On the other hand, I find it is a decided advantage, for it develops a type of person who knows his job and what is in the mind of other people concerning the work. It also prevents asking for obsolete or bad types of equipment, as opportunity is given to learn what is available in the market.

The advertising matter contained in our hospital publications is useful from an educational standpoint. I believe it is of value for hospitals to subscribe to trade papers for the heads of their departments and it is without question a very short sighted policy, indeed, for hospitals not to make a practice of securing hospital publications for the personnel to read. Courses in correspondence schools, night schools, and university extension departments develop some of our best and most practical workers.

No. 5

The greatest result we may expect to accomplish cannot be measured by pedagogic standards for there are too many cross currents of thought, personal interest and desires involved.

We must fix in the mind of our personnel permanent objectives which will appear to their imagination and at the same time give them a feeling of personal responsibility and pride in their work This may be done by reiteration without irritation, which is the best method to employ in teaching.

Three good objectives are the following:—

(1) To secure a dollar's worth of value for every dollar spent.

(2) To make everything go as far as possible.

(3) To have everyone feel that the success of the hospital depends on the proper discharge of each one's duty or, I may say, obligation to the hospital.

People are too prone to think of what the hospital owes them rather than what they owe the hospital.

We must create a desire in the personnel to learn how and after learning how to do a thing to do it for the pleasure of doing it.

It is necessary to create a oneness of mind through hard work, careful planning and cooperation. * * * * My idea of conducting a hospital is for everyone to be on the alert to find new methods or ideas which may be used to improve the service rendered by the hospital.

THE HANDLING OF ENDOWMENT FUNDS*

BY ALFRED C. MEYER, PRESIDENT, MICHAEL REESE HOSPITAL, CHICAGO, ILL.

THE RESULTS of a questionnaire on endowment funds for hospitals sent out to a number of hospital presidents and directors of community federations were presented by Alfred C. Meyer, president, Michael Reese Hospital, Chicago, Ill., at the evening session of October 31, of the twenty-fifth annual conference of the American Hospital Association.

The questionnaire was divided into three parts as follows: (1) Shall hospitals have permanent endowment funds? (2) How shall permanent endowment funds be invested? (3) How shall permanent hospital funds be safeguarded so that the purposes for which the donors gave them shall be carried out?

Of the thirty-seven replies received, thirty-one were in favor of the permanent endowment funds. Their reactions to the three phases of the questionnaire are given in the following digest.

Question 1

Shall Hospitals Have Permanent Endowment Funds?

The following answers and suggestions were received:

(Yes); but funds should not be too closely restricted in purpose. Hospitals will always be needed, and endowments make possible a greater amount of free work and also permit some research work to be done.

(Yes); three writers emphasize that there would be much less free work done if there were no endowments.

(Yes); writer feels that hospitals would not be progressive and would not develop into new fields if earnings and special gifts were sole sources of support.

(Yes); because of high operating costs, writer feels that hospitals need endowment funds, not only to enable free work to be done, but also to permit reduced cost for patients in moderate circumstances.

(Yes); but writer feels that community should be more and more informed as to kind and character of work hospital is doing.

(Yes); but writer, seconded by superintendent of his hospital, feels that efforts should be made to convince living donors that they should give money for immediate purposes of the hospital, rather than for permanent endowment. Failing in this, of course, funds are accepted for latter purpose.

There is practically a unanimity of opinion among those contributing to this symposium, that hospitals should have permanent endowment funds.

Question 2

How Shall Permanent Hospital Endowment Funds Be Invested?

The following practices are those now in use in the hospitals and federations represented in this symposium:

Safety of security first consideration; rate of return, secondary; bonds preferred.

Endowment funds should be invested by capable business men of considerable experience, without special restrictions.

Investment committee composed of members of the governing board should buy only first-class securities—those with a minimum of risk.

The funds should be invested in well diversified real estate bonds; a small proportion in industrial bonds; the balance in municipal, state and federal bonds. Safety of principal is first consideration.

Three say that their funds are invested by committee of board of trustees composed of bankers or business men familiar with investment of funds. Investments should be made in conservative securities giving fair yield with reasonable safety.

Funds should be invested by executive committee of board of trustees. First mortgage on real estate and government, state and municipal bonds recommended. Special approval of board of trustees must be secured before investments can be made in industrial securities.

Monies should be safely invested as surplus funds in a business would be.

There should be a finance committee of the board restricted to investments legal for trust funds.

Investments should be in bonds of approved quality and standing.

Bonds that are legal for saving's banks are the only forms of investment we make.

We invest all our funds in first-class bonds and mortgages.

There is a committee of the board which purchases only gilt-edge securities.

We buy only bonds that are legal investments for saving's banks.

Our investments are in bonds and first mortgages exclusively.

We have a finance committee purchasing substantial and conservative bonds and sometimes stocks.

Federal, state and municipal bonds and bonds in conservative public utilities.

Finance committee which purchases bonds only.

*Paper read by Alfred C. Meyer at the evening session, Wednesday, October 31, of the twenty-fifth annual conference of the American Hospital Association at Milwaukee, Wis., October 29 to November 3, 1923.

Four bank presidents constitute endowment fund investment committee and investments must conform to state laws for trust funds.
Funds should be invested in "widow's securities."
Special investment committee which buys securities of trust fund caliber.
First mortgages on real estate, first-class railroad bonds and United States Government bonds.
We have a committee of bankers which is not restricted to type of investment.
Government, municipal and state bonds.
We purchase only securities legal for saving's banks.
Matter is left to judgment of board of trustees.
Government, state or municipal bonds.
Finance committee makes all investments, which, however, must be approved by board of trustees.
Bonds and mortgages.
Mortgages, government, state and municipal bonds.

Considerable caution and conservatism are displayed by the various institutions represented in the above replies. The outstanding feature is the desire to guard the principal sums very carefully, and most boards of directors seem to feel that industrial stocks, and, to a large extent, industrial bonds, should be avoided. If permanent endowment funds are to be encouraged, every effort should be made to safeguard them, and the sentiment among boards of directors is strong that there is too great fluctuation in the margin of safety of industrial enterprises. This is particularly true in such smaller communities as are largely built up around some particular industry. If this industry is depressed, not only do the inhabitants of the town become financially weakened, but the hospital, counting upon income from this industry for partial support, suffers a shrinkage in endowment income also, just at a time when it should be strongest financially. Finance committees are favored, and if the hospital is small and there is no banker on the board of directors, it seems advisable to use one or more bankers in a consultant, or advisory, capacity. Of course, some hospitals are fortunate enough to have, as members of their boards, exceptionally able and conscientious financiers, who can disregard all the above safeguards; but these conditions occur rarely and boards must be alert enough to know when these special advantages have ended and should be prepared to go into the more conservative forms of investment at such times.

The by-laws of each hospital should specify the type of investments permitted for its endowment funds and the method for making such investments.

Question 3

How Shall Permanent Hospital Endowment Funds be Safeguarded so that the Purposes for which the Donors gave Them shall be Carried Out?

The following are excerpts from the replies:

Indorsement committees representing chambers of commerce or public boards should give attention to this point in connection with their investigations for indorsement. It should be the duty of state boards of charities and corrections, or some other public board, to check up endowment funds given for charitable purposes.
Ten expressed the opinion that the character of men and women constituting the board is the best guarantee possible.
Funds should be carefully watched by trustees, but donors should permit change of purpose under certain conditions.
A writer says that it is his opinion that there is great danger in the establishment of permanent funds so restricted that the income cannot be diverted to new needs when old needs cease to exist. Testator, or donor, should have sufficient confidence in trustees of hospital to give board reasonable latitude in the use of funds. If testator, or donor, is unwilling to do this, monies should be left to some foundation or trust fund for administration and direction.
Several reply that considerable latitude should be permitted boards of trustees to alter purposes of gifts, when changed conditions warrant.
State comptrollers should exercise some supervision over investments and expenditures of income from such funds. In addition, there must be confidence in the character of such trustees as may, from time to time, administer the hospital.
By the governance of a finance committee appointed from the board of trustees.
There should be a finance committee, whose business it is to see that pledges given when gifts are accepted are carried out.
Such gifts should not be accepted unless complete compliance is assured and provided for.
Books should be audited by expert accountants to see if promises are kept.
Three on the list think that the best plan is to entrust funds to community foundation, the trustees of which shall have authority to divert to other purposes than originally intended, as conditions warrant.
Character of trustees should provide for this; but times and conditions change; and thus endowment funds should have as few restrictions attached to them as possible.
One hospital has an endowment fund committee composed of four bank presidents who have the responsibility of seeing that such pledges are kept.
Annual audit is recommended to determine whether conditions are being complied with.
One hospital president does not believe in endowments for specified purposes.

The general feeling is that enough confidence should be felt in the trustees, or directors, of hospitals, to entrust the matter to them. Some feel, however, that because the personnel of boards change, an outside agency, like the state, or an auditing company, should check up the funds from time to time. More leeway should probably be given to trustees in spending the income from these gifts than has been the custom. Rigid specifications are not advisable when funds are to continue for long periods of years, as conditions change so. Persons reading this report could probably adduce many instances of funds that have outlived their usefulness and which could be diverted to beneficial purposes were not the conditions of the original gift so inflexible. Prospective donors should be educated to the view that trustees of hospitals be permitted to alter terms of gift, with certain reasonable checks; and trustees should so educate themselves as to be worthy of such trust.

Replies to the questionnaire were received from the following thirty-one persons:

A. D. Baldwin, president, Babies' Dispensary and Hospital, Cleveland, Ohio.
W. T. Barbour, president, Grace Hospital, Detroit, Mich.
Fuller F. Barnes, president, Bristol Hospital, Bristol, Conn.
Charles D. Barney, president, Hahnemann Medical College and Hospital, Philadelphia, Pa.
Mrs. Morris B. Belknap, president, Children's Free Hospital, Louisville, Ky.
E. V. Benjamin, president, Touro Infirmary, New Orleans, La.
C. S. Blackwell, chairman, Toronto General Hospital, Toronto, Can.
Homer W. Borst, executive secretary, Community Chest, Indianapolis, Ind.
Otto F. Bradley, executive secretary, Minneapolis Council of Social Agencies, Community Fund, Minneapolis, Minn.
Dr. E. M. Brown, president, St. Alban's Hospital, Sheldon, Vermont.
Asa G. Candler, president, Wesley Memorial Hospital, Atlanta, Ga.
Raymond Clapp, secretary, investigating committee, Cleveland Community Fund, Cleveland, Ohio.
C. B. Clark, treasurer, Theda Clark Memorial Hospital, Neenah, Wis.
Edith Cushing Marshall, president, Hospital for the Women of Maryland, Baltimore, Md.
Paul L. Feiss, president, Mt. Sinai Hospital, Cleveland, Ohio.
H. L. Fritschel, Milwaukee Hospital, Milwaukee, Wis.
L. A. Halbert, executive secretary, Council of Social Agencies, Kansas City, Mo.
Hugh H. Herdman, executive secretary, Portland Community Chest, Portland, Ore.
F. G. Hogland, president, Swedish-American Hospital, Rockford, Ill.
M. M. Holmes, trustee, Olean General Hospital, Olean, N. Y.
Miss Emma F. Ingalls, treasurer, New Hampshire Memorial Hospital for Women and Children, Manchester, N. H.
Mrs. W. B. Johnson, president, Rome Hospital, Rome, N. Y.
Dr. S. E. Josephi, treasurer, Hospital of the Diocese of Oregon, Portland, Ore.
Guy T. Justis, social service secretary, Denver Community Chest, Denver, Colo.
John A. Kenney, M.D., medical director, Tuskegee Normal and Industrial Institute, Tuskegee, Ala.
Sherman C. Kingsley, executive secretary, Welfare Federation, Philadelphia, Pa.
Oscar W. Kuolt, service secretary, Rochester Community Chest, Rochester, N. Y.
E. J. Larrick, executive secretary, Better Akron Federation, Akron, Ohio.
David C. Liggett, director, Welfare League, Louisville, Ky.
E. Mallinckrodt, president, St. Luke's Hospital, St. Louis, Mo.
C. A. Mallory, president, Danbury Hospital, Danbury, Conn.
W. J. Norton, secretary, Detroit Community Fund, Detroit, Mich.
Herbert Parsons, president, Memorial Hospital, New York, N. Y.
Samuel Sachs, chairman, finance committee, Montefiore Hospital, New York, N. Y.
Elwood Street, director, The Community Fund, St. Louis, Mo.
Chalmer B. Traver, executive secretary, Centralized Budget of Philanthropies, Milwaukee, Wis.
F. A. Winter, assistant secretary, board of trustees, St. Luke's Hospital, Bethlehem, Pa.

"THE LANCET" TO CELEBRATE HUNDREDTH ANNIVERSARY

A dinner to be given in celebration of the completion of the hundredth year of *The Lancet* will be held in London on November 28, 1923. The chair will be taken by Sir Donald MacAlister, president of the General Medical Council of Great Britain, supported by seven distinguished men of the profession in England.

SHOULD GENERAL HOSPITALS ESTABLISH DEPARTMENTS FOR PHYSIOTHERAPY?*

By JOHN HARVEY KELLOGG, M.D., Superintendent, Battle Creek Sanitarium, Battle Creek, Mich.

As the modern hospital is the workshop of modern medicine where the sick may benefit by the latest discoveries in scientific methods of cure, it should be equipped to make these methods of treatment practical. Among the scientific developments of the past few years, physiotherapy has found its place as a fundamental curative agency for the sick. Since the natural physical properties of air and water, light and exercise have come to be recognized as the greatest curative agents, it is necessary for the hospital to be equipped to make the most effective use of these physiotherapeutic agents. In order to do this it is not necessary, as Dr. Kellogg points out, for the hospital to have a department of physiotherapy, but every hospital can and should have a personnel which has a thoroughgoing theoretical and practical knowledge of physiotherapy. Moreover training in our medical schools will have to be more adequate and more efficiently organized.

A DEPARTMENT devoted to physiotherapy may not be needed by every hospital, but every hospital needs physiotherapy. Every hospital does not need a dining-room, but every hospital needs food for its patients and a dietitian or nurses and physicians trained in the principles of nutrition and scientific feeding. So every hospital needs physiotherapy and a physiotherapeutist.

Within the last half century a most remarkable evolution, one may even say revolution, has occurred in methods of dealing with the sick. The marvellous light thrown upon life processes, normal and pathological, by the revelations of physiology, bacteriology, and physiological chemistry and the exposures of the fallacies of old therapeutic notions and the inertness or inadequacy of the great majority of drugs made by experimental pharmacology and clinical observation checked up by modern instruments of precision, have so completely transformed the practice of medicine that the war of the "pathies" ceased years ago for lack of anything of interest to war about. Everybody knows, nowadays, that sick people are not cured by either big pills or little pills, but by the *vis medicatrix naturae*. As Dietl., a famous disciple of the great Rokitanski, declared, "Nature creates and maintains, therefore she must be able to heal." And, as the late Dr. Winternitz, the father of scientific hydrotherapy, insisted, "It is the blood that heals." The ancients knew this, and recognized that "The blood is the life;" but the great cloud of ignorance and superstition which submerged the world during the "Dark Ages" obscured this vitally important truth which modern physiology has brought out again and made to shine with greater luster than ever. We have a very few specific drugs which cure by destroying parasites of some sort; but with very few exceptions, the agents which are really potent in combating disease are those which modify the blood or the blood supply, and these agents are almost wholly those which belong to the domain of physiotherapy, which includes all therapeutic measures other than drugs and psychic influences.

The modern general hospital is supposed to be a place where the sick may receive the benefit of every curative method and resource recognized by scientific medicine, and there seems to be no good reason why the modern general hospital should not realize this ideal in its equipment and the personnel of its staff of physicians and nurses.

If the question of expense is raised, the objection is easily answered by the fact that for a very efficient application of physiotherapy very little expensive or special equipment is actually required. The great essentials of physiotherapy, in addition to diet, are air and water, at different temperatures, light and exercise, active and passive. These most potent of all means of modifying metabolism and nutrition may be applied in a thoroughly efficient manner and with most satisfactory results without the use of very expensive or elaborate apparatus. The most important part of a physiotherapeutic equipment is a thorough, theoretical knowledge of physiotherapy. With this, great results may be attained with little or no special equipment; without it, the most elaborate equipment is useless. Not so very long ago, I happened to visit a large hospital which possessed a most elaborate and up-to-date physiotherapeutic outfit. The hydriatic equipment was particularly elaborate and expensive. On being introduced to the head nurse, I was at once beset with questions about hydrotherapy. Said the nurse, "Do tell us how to use hydrotherapy. The doctors send us down patients every day with a prescription for hydrotherapy, but they don't tell us what to do." The doctors were not to be greatly blamed, for does not the learned Osler say many times over in his great work on practice, "If the measures above indicated fail, try hydrotherapy." The teaching of physiotherapy in our medical schools is still so inadequate and inefficient that the student has no opportunity to become sufficiently familiar with the technic to be able to make an intelligible prescription. Although now recognized as the chief part of therapeutics, it receives the least attention. Very often the teachers are themselves little familiar with the subject. The late Professor Brieger, the eminent German chemist, who held his place on the faculty of the imperial medical school of Berlin as professor of physiotherapy, told me that when he got his appointment he went to Kneipp's Water Cure for three weeks to learn hydrotherapy. This neglect of physiological therapeutics by our medical schools is without doubt responsible for the existence of osteopathy, so-called chiropractic, and a dozen other medical cults.

Water, as a means of producing thermic impressions and thereby influencing the vasomotor nerves and centers, is the most potent as well as the most versatile of all curative agents. By its proper use, even with such simple means as a wet rag, it is possible to control almost at will the blood circulation of any vital organ, and thereby to produce therapeutic effects quite surprising to those who are not familiar with the results obtainable with this wonderful agent when skilfully applied.

*Read at the evening session, Tuesday, October 30, of the twenty-fifth annual meeting of the American Hospital Association, held at Milwaukee, October 29-November 3.

A room or series of rooms fitted up with expensive appliances makes a fine showing in a hospital, and produces a great impresson upon visitors and may be made of real and great service; but the things really needed in the general hospital is such an intimate acquaintance with the resources of physiotherapy as will in large measure eliminate the use of hypnotic drugs to produce sleep, of medicines and mineral waters to stimulate delinquent colons, and even of drugs for relief of pain.

When I was a student at old Bellevue fifty years ago, I one day heard two of the interns discussing the treatment of delirium tremens, cases of which were very numerous at Bellevue in those days of cheap whisky. The regulation treatment was confinement in a cell and opium and chloral in massive does. One of the interns said, "I often find 'em dead in the morning." "Yes," said the other, "I slip one every now and then, but that's the only way to keep them quiet." A year or two later, when I encountered my first case of acute alcoholic mania, I wrapped the patient in a wet sheet to keep him in bed and discovered that the neutral pack not only kept him still but sent him off to sleep.

In discussing a paper which I read some years ago before a very active medical society, the superintendent of a large state hospital for the insane, the late Doctor Edwards, stated that in recently comparing their present use of chloral and other hypnotic drugs with their practice twenty years before, they had found that with 2,000 patients they were now using less of such drugs in a year than they formerly used with 600 patients every week. He added, "If a patient has insomnia, we just put a wet rag on somewhere and he goes right off to sleep." The effective use of water to produce sleep is not quite so easy as that, but the neutral bath and allied measures are so remarkably efficient in producing sleep that the use of sleep-producing drugs is rapidly becoming obsolete in the leading hospitals for the insane in this country as well as in France and in other European countries where they have been long employed.

Analgesic Effects of Heat

The analgesic effects of heat are among the most remarkable of all therapeutic effects. Heat kills pain. Just how, nobody knows, as no one has yet explained the action of opium or of other pain-relieving drugs. Of course, heat is not a complete substitute for opiates, but it will relieve at least nine-tenths of all the pains for relief of which opiates are commonly given, and has the great advantage of being wholly free from the numerous dangers and disadvantages of opiates. Every hospital should be supplied with conveniences for quickly preparing fomentations, with thermophores and electric photophores, as well as hot-water bags and other efficient means of applying heat. These simple and inexpensive appliances are far more important than an elaborately appointed department filled with expensive apparatus.

Nevertheless, the physiotherapy department with specially trained persons in charge is just as essential for the complete equipment of a modern hospital as is an operating room, an examining room or a laboratory. In such a department should be found appliances for the efficient use of hydrotherapy, thermotherapy, phototherapy, mechano-therapy, electricity, corrective gymnastics, automatic exercise and indoor and outdoor gymnasiums. For many years I have made a close study of appliances adapted to physiotherapy and have tested every new apparatus that has become known to me and have selected out of a great number of more or less useful appliances those which have proven to be of real service. Chief among these I may mention the following, all of which are in use at the Battle Creek Sanitarium, most of them having been in practical use for many years.

Hydriatic Apparatus

The douche is useful but by no means the most essential part of a hydrotherapy outfit, although so much emphasis has been given to douche apparatus in recent years that in the minds of many it seems to be regarded as the one thing needful for a complete equipment. Many of the newer hospitals are supplied with expensive douche appliances which are used scarcely more often than are the fire extinguishers. The fact is the douche is an appliance that requires more skill in its use and is less frequently called for in a general hospital than a large number of other much simpler and far less expensive appliances, such as sitz, leg, arm and foot baths, and full bath tubs adapted to the neutral bath. The simple shower and spray bath with a good thermostat will satisfactorily supply the needs of the ordinary hospital. The first douche apparatus ever used in a hospital consisted of a box with a perforated bottom which was supported over the patient while water was poured in. This mother of douches, used in a hospital in Edinburgh 200 years ago, though crude, was most efficient in combating fever.

So long as the idea prevails that an expensive douche apparatus is a whole hydrotherapeutic outfit, hydrotherapy will make little progress in hospital practice. The douche is exceedingly useful in certain classes of hospitals. particularly institutions for the insane and those that are especially devoted to nervous diseases and non-surgical or gastro-intestinal disorders. The investment required need not be great. A simple appliance which may be attached to a wall slab will accomplish everything that can be done with the most elaborate and expensive apparatus.

Phototherapy and Aerotherapy

Light supplies not only heat but other forms of radiant energy which are highly potent and vital stimulants. When light rays fall upon the skin the chemical rays act upon the superficial layers producing, when very intense or long continued, an erythema. The luminous rays, however, penetrate deeper. As they penetrate an opaque substance, like human flesh, they meet with resistance and are converted into the longer, infra-red or heat rays which penetrate still farther. The electric light is more than a complete substitute for sunlight for the reason that in passing through the upper atmosphere the shorter ultra-violet rays and the longer infra-red rays are almost entirely absorbed by oxygen, which is thereby converted into ozone.

The electric light in its various forms must be regarded as a very essential part of every hospital. By the use of this artificial light, all the benefits of sunshine may be obtained and at times and seasons when sunlight is not available.

A beam of light contains all the different forms of heat rays, luminous and non-luminous, from infra-red to the top of the gamut. This is clearly shown by the spectrum. However, it is to be remembered that when luminous rays enter the body, they are quickly converted into infra-red, so that all these rays in practical use become infra-red whether luminous or non-luminous.

Every general hospital should be liberally equipped with sun porches or an outdoor gymnasium for the warm season and sunrooms for use in cold weather. I have made use of the sun-bath extensively for more than forty

years, and have found it invaluable not only as a general vital stimulant but as a means of promoting the healing of indolent wounds.

It is doubtless true, as Rollier has observed, that all the benefits of sun-bathing are not to be attributed to the actinic rays or to the effects of light, but are, in part, due to the thermic effects produced by contact with cool air. He finds, for example, that sun-baths are more efficient in the early part of the day, when the air is cool, than in the middle of the day, when the air has become heated. In the use of sun-baths in the outdoor gymnasium, I have, for many years, made use of the cool shower bath as a means of combating the depressing effects of excessive heat during hot weather. By alternating exposure to the sun's rays with short, cool baths, most powerful tonic effects may be produced.

Our long, cold season nearly half a year, and the large proportion of cloudy days, greatly lessens the value of sunlight in practical therapeutics; but, fortunately, all of the advantages of sunlight may be obtained by an efficient use of the electric light. For local effects, the photophore, in which the use of the incandescent lamp is a source of light and heat, and the arc light are most useful and efficient. Every hospital should be supplied with a number of these appliances which are now available in forms adapted to all sorts of medical and surgical cases in which the applications of heat or light is desirable.

To obtain the general effects of light when sunlight is not available is a somewhat more difficult problem. By combining arc lights with Cooper-Hewitt tubes and the quartz light, all of the effects of sunlight may be readily secured. In a cabinet which, for convenience, we will call "the sunlight bath," there are six arc lights, two Cooper-Hewitt tubes, and one quartz lamp. By this combination, the effects of the most intense sunlight are obtainable. In fact, it is even possible to produce in ten minutes a slight degree of erythema, if this is desirable.

Electrotherapy

While less useful than light as a therapeutic means, is nevertheless a most important feature of a physiotherapeutic hospital outfit. Unfortunately, electrotherapy has always been more or less in disrepute. This highly useful agent has been discredited by the extravagant claims made for it by so-called electrotherapeutists and by the attempt to make it a panacea, whereas its useful application is really limited to certain classes of patients. It is true that electricity is useful as a general tonic, but for this purpose cold water, cold air and sunshine are so much more potent and practical that its value is overshadowed.

The most important use of electricity in connection with a hospital, outside of its diagnostic uses, is as a means of passive exercise. Two purposes are served, first, the development of weak or paralyzed muscles; and, second, stimulation of tissue change, or metabolism. There is a great demand for the use of electricity for both of these purposes in hospital practice. Improved muscular development is required not only in cases of paralysis but in a great number of cases in which the muscles are weak because of disuse through sedentary life, bad posture, etc.

As a means of increasing metabolic activity, suitable applications of electricity may be advantageously made in a very large number of hospital cases. We are, I believe, prone to forget that the confinement of a patient in bed produces nutritive disturbances which ought to be combated by suitable measures. Modern metabolism studies are also showing that there is a very considerable number of persons whose metabolic rate is below normal and requires stimulation. For all these cases, electricity is a most valuable resource. The best form of electrical current for this purpose is the sinusoidal. I had the good fortune to discover the value of this current as a mode of passive exercise nearly forty years ago. I was carrying on a series of experiments with electrical currents from all available sources and happened upon a form of current which produced vigorous and painless muscular contractions. I saw at once the value of this current for automatically reducing muscular exercise and have made extensive use of it ever since. A few years later, D'Arsonval, of Paris, in experimenting with high frequency currents, discovered a form of current which produced painless contractions and which, on investigation, I found to be identical in form with the current of which I had made use. The current is known as the sinusoidal current because of its form. Its painlessness is due to the fact that in the faradic current the change of direction occurs at the point of highest intensity.

The most efficient forms of the sinusoidal current for influencing metabolism are the sinusoidal bath, by which the metabolic rate may be easily doubled without the slightest discomfort to the patient, and the automatic exercise chair, by which the metabolic rate may be increased to any degree desired—from 100 per cent to 600 or 800 per cent.

Another electrical appliance of proven value is the diathermy, or thermo-penetration apparatus, a high tension apparatus which supplies the current which is practically identical with the so-called wireless current, but of much lower tension. In the passage of this current through the body, the electrical energy is converted into heat and thus by this means heat may be applied to any internal viscus with the same exactness as that with which heat may be applied by other means to the surface of the body. This agent is found exceedingly useful in making heat applications to deep-seated organs such as the lungs or heart and large nerve trunks and certain joints, and produces highly valuable results.

No general hospital should be regarded as properly equipped without these useful electrical appliances.

Mechanotherapy

Mechanotherapy, like electrotherapy, has been greatly discredited by the excessive claims made for it in the attempt of the partisans of this method to accomplish by mechanical means results which are much more efficiently obtained by hydrotherapy or electrotherapy. After careful study of all the various forms of apparatus which have been produced in this country and in Europe for use in mechanotherapy, and after an experience of more than forty years with this line of therapeutics, I am thoroughly confirmed in the opinion that certain results may be accomplished more efficiently by suitable mechanical appliances than by any other means and that at least a few of these appliances might be advantageously added to the equipment of the average general hospital.

Perhaps the most useful of these appliances are means for applying a kneading movement to various parts. By means of a simple device, the oscillo-manipulator, kneading movements may be applied to any part of the body and the movements may be graduated from the most gentle applications to the most vigorous and thoroughgoing. Applications of this sort are highly valuable for patients subjected to long confinement to bed as the result of traumatisms or after serious operations, in cases

of paralysis and in the wasting of muscles which results from chronic joint disease. Mechanical kneading is also most useful in connection with the rest cure, in convalescing cases and in all cases in which it is desirable to promote local or general nutrition. Mechanical massage, as well as manual, has the advantage that it promotes anabolism, or constructive metabolism, without materially increasing catabolism, or destructive change. Exercise promotes constructive metabolism but at the same time enormously increases destructive metabolism. Hence, in cases in which it is desirable to promote tissue-building and an increase of fat and blood, passive exercise and massage render invaluable service. The average patient cannot afford to pay for the services of a trained manipulator. This opens a wide field for the mechanical manipulator, which is in practical use for securing the general systemic effects of massage fully as thorough-going and efficient as is manual massage. Mechanical massage has the advantage that it may be applied by the patient himself or by an ordinary attendant and thus may be utilized in a great number of cases which might not be able to afford the expense of manual massage.

A large hospital should provide a variety of mechanical appliances for administering passive movements for the mobilization of the joints and appliances for promoting exercise, such as pulley weights, the riding horse, the stationary bicycle, rowing machines, etc. For the efficient use of exercise as a therapeutic measure, a suitable means should be provided for obtaining accurate information regarding the patient's muscular system. A thoroughly scientific method requires the testing of the strength of each of the larger groups of muscles and comparison of the results with normal standards. This is best done by making a graph, which will show at a glance the defective groups of muscles and the degree of deficiency in strength. This method, which has been in use at the Battle Creek Sanitarium for nearly forty years, was adopted many years ago by the government military schools at Annapolis and West Point. Every cadet who enters Annapolis is examined by this method and required to bring up the strength of all the weak muscles to the 100 per cent line before he is allowed to spend any time watching the ball games and other competitive sports.

Attention must be given, also, to posture. This applies to bed patients as well as ambulant cases. The study of the outlines of the body are often highly suggestive of deeply-seated morbid conditions to which attention should be given. For example, a round back and a protruding abdomen always indicate a low-standing diaphragm. Since the pericardium is attached to the diaphragm, when the diaphragm is dragged down, the heart is dragged down with it, and with every heart-beat the heart muscle is compelled to do, in addition to its normal work, a large amount of unnecessary and unnatural work in lifting the diaphragm and the heavy viscera which are attached to its under surface. These patients with flat chests, round backs and prominent bellies, have no endurance when they are on their feet and quickly get out of breath when they undertake exercise of any sort because of the extra work required of the heart. These patients are also very likely to suffer from the strain upon the sacro-iliac and intervertebral articulations, especially of the lumbar region, which is the natural consequence of a position in sitting or lying which puts these joints under undue strains. These strains often give rise to severe backache, the cause of which is frequently not suspected. Hospital patients often suffer greatly from this cause. Such patients may be almost instantly relieved by simply propping up the hollow of the back with sandbags or cushions. The backs of seats and rolling chairs provided for convalescing patients in hospitals as well as the seats in ordinary use in homes, churches and theaters and elsewhere, almost invariably ignore the natural requirements of the contour of the body and, affording no support for the lower part of the back, compel the feeble patient to crumple up in order to secure the support which his lack of strength requires.

The shadow-graph affords a convenient means for the study of the outlines of the body, and is an aid to diagnosis, and is especially useful as a means of demonstrating to the patient himself the necessity for observing correct posture in sitting and lying as well as in exercise and work.

The time allowed this paper is too brief to admit anything more than a very cursory review of the subject. As a matter of fact, from the writer's standpoint, physiotherapy is by far the greater part of therapy, and hence methods and appliances for employing the various physical agents by which the body functions may be influenced should constitute the major part of the hospital equipment and organization. I see no reason why the general hospital should not provide its patients with the same advantages which are afforded by the up-to-date sanitarium.

Prophylactic Physiotherapy Paramount

In conclusion of this very incomplete paper, I will call attention to what may be termed prophylactic physiotherapy, which I consider as important as any, if not the most important of all. This consists in the systematic education of the patient while under treatment in right habits of living. The majority of patients who visit the general hospital are brought there directly or indirectly as the result of wrong habits of life. Most chronic ailments are the result of errors in eating, neglect of exercise and other infractions of the rules of health which, if continued, will bring the patient back or take him to some other hospital, and will ultimately prematurely end his life. While the medical or surgical care of the patient must, of course, be the first and principal aim of the hospital, the proper education of the patient during the period of his hospitalization, so that he may be so far as possible insured against the necessity of again seeking hospital care, should be made a regular part of the work. In general, patients are eager to learn what they may do to prevent a return of their troubles, and the patient's program usually gives him ample time for receiving such instruction as may be of incalculable value to him. The opportunity is one which should not be neglected. Every general hospital ought to have associated with its physiotherapy department a health director capable of instructing patients in an entertaining and convincing way, so that when the sick man leaves the hospital he may carry home with him not only a body which has been improved by the treatment which he has received, but, through the teaching and training which have been given him, a new set of habits through which he may not only maintain the improvement made, but may for a long time afterwards continue to improve in bodily fitness and efficiency. The hospital has a wonderful opportunity for service as an educational factor which should not be neglected. The social welfare service connected with some large hospitals is a beginning in this line which should be developed and expanded until health education and training are everywhere recognized as an essential feature of hospital organization and administration.

DIETITIANS HOLD SIXTH ANNUAL CONFERENCE

THE sixth annual meeting of the American Dietetic Association was held in the Claypool Hotel, Indianapolis, Ind., October 15 to 18. The number in attendance at this meeting and the enthusiasm, as well as serious interest manifested, attests the spirit with which the members of this association attend their meetings. The enrollment showed only two hundred and fifty but there were many more than that in attendance. The Indianapolis Association acted as hosts to the visitors, and had charge of local arrangements for the convention. Their hospitality and courtesy were in evidence at all times.

The section on administration had charge of the Monday morning program. Miss Effie Raitt of the University of Washington was chairman of this section. Miss Raitt gave a splendid survey of the present status of dietitians' work. She brought out that organization, with a clearly defined outline of work, responsibilities and authority of the dietitian, as an important factor in the hospital today.

"The three factors determining the patient's welfare," said Miss Raitt, "are the doctors, the dietitian and the nurse. The doctor has absolute authority, the head nurse may have some, but in too many instances the dietitian has to report to a board of directors, a bevy of superintendents, and the doctor. This condition should not maintain. Certainly there should be a close contact between the doctor and the hospital dietitian, but to the extent that there is interference with a skilled and thorough-going dietitian's program, just to that degree will the food problem in a hospital become complicated."

Probably the best graphic illustration of the dietitian's part in the hospital organization is the chart worked out by Miss Raitt.

Other papers read at this session were "Qualities Necessary for Success in Commercial Food Work," by Annie Jewett, board of directors, American Restaurant Association; and "Supervision of Food Preparation," by Ruth Lusby, University of Wisconsin. Then followed a discussion on "Food Service to Nurses," by Harriet Wells, Brooklyn Hospital; Maude Perry, Montreal General Hospital and Breta Luther Griem.

Monday afternoon the section on dietotherapy, Miss Lautz, chairman, presented the following program: "How May the Dietitian Best Cooperate with the Physician?" by Dr. Russell Wilder, Mayo Clinic, Rochester, Minn. "Insulin Treatment and its Relation to Dietetic Management of Diabetes Mellitus," by Dr. A. L. Walters; "The Standardization of Technical Methods used in Dietotherapy," by Amalia Lutz, Peter Bent Brigham Hospital, Boston, Mass.

Dr. Wilder's discussion of the work done in dietotherapy at the Mayo Clinic was an inspiration to all. For some time the results obtained by Dr. Wilder and his staff, have been known and the Diabetic Primer which he and Miss Foley, the dietitian, have produced, and which is now in its second edition, are greatly appreciated. As Dr. Wilder's paper will be published in THE MODERN HOSPITAL in the near future, it will not be discussed here.

Dr. Walters gave a concise but very clear statement of the three forms of diabetes, renal, insipidus, and mellitus, their symptoms and treatment, with and without insulin. He stressed the fact that a well planned diet is even more important when insulin is used than when it is not.

Miss Lautz, Peter Bent Brigham Hospital, Boston, gave a valuable report on methods of weighing and calculating diets, with numerous time-saving suggestions.

At the banquet Monday evening short addresses were made by Dr. Charles P. Emerson, dean, Indiana College of Medicine; Laura R. Logan, R.N., University of Cincinnati, president of National League of Nursing Education, and Lulu Graves, honorary president, American Dietetic Association.

Dean Emerson made the statement which is heard so frequently from medical men that diet is replacing the use of drugs in medical therapeutics and that the medical man looks to the dietitian with greater expectation than to the pharmacist. After hearing this repeated many times we cannot help wondering why the medical schools

Assembly of delegates who attended the sixth annual convention of the

continue to teach drugs and ignore dietetics, or give this subject very superficial attention.

Dr. Wheeler, chairman of the section on education, gave an interesting talk at the opening of the Tuesday morning session on the methods of teaching dietotherapy. Miss Boller told how the patients were taught at the dispensary at Rush Medical College, Chicago, and Mrs. Bryan told of the instruction given at Presbyterian Hospital, New York, to medical students, doctors, nurses, and others. Mrs. Huddelson, New York, N. Y., also read a paper on teaching of patients methods of dietary observance.

Tuesday afternoon was given over to sight-seeing, including a visit to the Polk Dairy and the plant of the Eli Lilly Company.

The evening program included papers by Dr. Louis H. Burlingham, Barnes Hospital, St. Louis, Mo., "What Does a Hospital Superintendent Expect of a Dietitian?" and Dr. Amy Daniels, University of Iowa, Iowa City, Ia., "How Can the Home Economics College Improve the Preparatory Training of the Hospital Dietitian?" These papers were followed by a discussion.

The point was made more than once during the meetings that while it is the dietitian's job to feed the people of her institution, prevent waste, cut down the cost, do numerous types of teaching, act as consultant, executive, and possibly a few other things, she must constantly keep in mind that she is going through a preliminary period which may be chiefly disciplinary. While we may now be doing many things we do not want to do we must do these things until circumstances and time permit us to do that which we want to do.

The section on social service on Wednesday morning began its program with a survey of Polish dietaries by Mrs. Gertrude Gates Mudge, chairman of the section. This was followed by "Special Class Problem," Helen Parsons, University of Wisconsin; "The Place of Home Economics in Family Case Work," Frances Preston, Cleveland Associated Charities, and a discussion "The Dietitian and the Hospital Clinic," led by Miss Proudfit.

It is worthy of note that the Chicago social workers found in their work among the Poles and Italians with the families having an income of $1,000 or less, that the Poles spent 84 per cent of this income for food and the Italians 77 per cent. Suggested remedies for relieving the conditions of these foreign-born families who are suffering from poverty are, education on dietaries, birth control, and higher wages. The latter on the basis of their skillful hand work and faithfulness.

Wednesday afternoon Miss Marlatt entertained the association with a brief account of her experiences during the year she has been traveling in Europe, Arabia, and many other places of interest. A business meeting followed.

In the evening many good things were crowded into the final session. Miss Lydia Roberts, University of Chicago, presented a study which has been made by the students in the class in dietetics of the college of education. Miss Roberts proved that a fairly accurate study can be made with a group of everyday children in their everyday life. She also proved that there is no "average child."

Miss Little told of the system of feeding the students at the University of Wisconsin.

Miss Hamlin, director of the Hospital Library and Service Bureau, Chicago, Ill., told of the immense amount of information the bureau has succeeded in accumulating and of the way in which the bureau may be of service to dietitians.

Dr. Barnard, of the American Institute of Bakers, told us a few of the things being done by this Institute. We, as dietitians, welcome this very worthy work and should keep in touch with the activities of this organization.

In addition to the regular sessions held, a diversion was introduced by a delightful tea given in the banquet room of the Claypool Hotel.

The exhibits were interesting and educational as usual. Many new devices were shown this year in addition to those which have stood the test of time.

The following officers were elected for the coming year: President, Mrs. Octavia Hall Smillie, Andalusia, Ala., (re-elected); first vice-president, Miss Effie Raitt, home economics department, University of Washington, Seattle, Wash.; second vice-president, Miss Rose Straka, Presbyterian Hospital, Chicago, Ill.; secretary, Mrs. Breta Luther Griem, (re-elected); treasurer, Miss Anna Boller, Chicago Free Dispensary, Chicago Ill. (re-lected).

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1176 HOSPITALS MEET "MINIMUM STANDARD" OF A. C. OF S. IN 1923*

THE American College of Surgeons has just completed the sixth annual survey of hospitals in the United States and Canada. The results of this survey give evidence of steady progress toward hospital betterment and an increasing interest in the hospital standardization movement. Not only are the medical profession and the hospital people themselves vitally interested, but the public is developing a widespread belief in this effort for improved and highly efficient care of the sick.

Since the year 1918, when the American College of Surgeons first actively undertook the standardization of hospitals, there has gradually developed a new era in hospital service. This era is characterized by the development of more efficient institutions standing for the utilization of every means known to medical science for the best possible care of the patients. A definite standard has been established whereby hospitals may measure their efficiency in terms of service to the sick and end-results. The standard is now well beyond the experimental or trial stage. After six years of its application in large numbers of institutions on this continent, those charged with its promotion find no reason for altering any of the procedure laid down therein. This standard is based on a service so broad as to embrace the activities of every person who has anything whatsoever to do with the care of the patient, the hospital "perspective" on whom the accumulative services of the institution must be focused. Every person in a hospital organization, no matter what his or her status may be, has a definite responsibility and share in the proper care of each individual patient and in the obtaining of the best possible result.

What Hospital Standardization Is

Hospital standardization is an international movement including in its scope all general hospitals of fifty beds and over in the United States and Canada. It is carried on by the American College of Surgeons whose membership includes at present over 6000 surgeons in both countries as well as a number from South America. One of the outstanding features in the progressive program of the college is the movement for better hospital service, more widely known as hospital standardization. This movement, through the application of its inherent principles and by means of an annual survey, aims at establishing and maintaining in hospitals an organized personnel working as a group in the best interests of the patient. It demands that there be provided the necessary facilities for scientific diagnosis and treatment and that these facilities be utilized under competent direction. It requires that there be a careful and accurate recording of all data concerning each patient. This is necessary in order that there be a thorough study and investigation of each case to insure (a) an early, accurate, and comprehensive diagnosis, (b) the correct and effective treatment, (c) the best possible end-result. It is the desire of the college that, through the carrying out of this program, every individual requiring hospital treatment, regardless of race, color, creed, or social status, shall receive the benefits of the most up-to-date and scientific procedures known to modern medicine. This is a humanitarian service with the basic idea that our hospitals are conducted entirely for the benefit of the patient.

There is no desire to interfere with the individual initiative of any hospital. The standard set is the minimum requirement. Each institution is encouraged not only to reach that standard but go as far beyond it as possible. The requirements laid down are fundamental. They are the basic principles which are absolutely necessary to make the hospital a scientific institution, capable of rendering the best service to the patient, to the public, and to the profession.

Through the medium of the hospital visitor, hospital conferences held in various parts of the United States and Canada and widespread correspondence, the foundation of hospital standardization has been laid and the superstructure is now being well developed. The program of the American College of Surgeons is presented annually to all general hospitals of fifty beds and over in the United States and Canada. This is not done by correspondence but by personal visits of carefully selected investigators. These men are sent out from headquarters to visit the hospital by appointment and carefully survey the institution. They report their findings according to a definite and prescribed form laid down by the college. When possible they meet the various groups in conference, explaining the workings of the program and discussing such matters as pertain to the improvement of the service. The visitor reports to headquarters and a follow-up is maintained. The procedure, therefore, is to analyze through personal investigation the general hospitals of 50 beds and over in the United States and Canada, in terms of the minimum standard of service.

What the Minimum Standard Requires

The minimum standard of the American College of Surgeons presents the following principles as essential to its attainment.

(1) The doctors practicing in the hospital shall be organized as a staff. This organization may be carried out either an "open" or a "closed" hospital. The staff should elect from time to time a chairman and secretary. Much of the success of the staff organization and staff meetings is dependent upon the efficiency of these two officers who must exercise good leadership and initiative.

(2) The medical staff of the hospital shall be competent and ethical. The American College of Surgeons is absolutely opposed to the practice of "fee-splitting" in any manner whatsoever, and it is required that the staff of every hospital accepted under the minimum standard shall take a very definite stand in this regard.

(3) The medical staff shall draw up rules and regulations for the guidance of the professional work in the hospital. By means of such rules and regulations the medical work of the institution is co-ordinated and systematized.

(4) The medical staff shall hold conferences periodically, at least once every month, for analysis and review of the work carried on in the institution. At these conferences there should be a careful review of the medical work during the intervening period. It is advisable that a definite agenda be prepared for each meeting. This agenda should include consideration of the following: (a)

*Excerpt from the report for 1923 of the American College of Surgeons Hospital Standardization Committee together with a complete list of hospitals of fifty or more beds in the United States and Canada which meet the minimum standard of the College.

the patients now resident in the hospital; (b) the patients discharged since the last staff meeting and the results of their treatment with special reference to the unimproved, infected, or complicated, and the deaths; and (c) everything pertaining to the betterment of the hospital service.

All discussion or criticisms at staff meetings should be of a constructive nature. A record of the proceedings should be kept by the secretary. The monthly analysis sheet has been found to be of great value in the staff conference.

(5) There shall be a complete medical case record of every patient passing through the institution. There are certain fundamental requirements for a good case record system in any hospital. There is, first of all, the realization that the case record is a necessary part of the care and treatment of the patient. There must be the facilities for securing and filing of such records. The component parts should be carefully assembled and when complete form a comprehensive document setting forth the following information: identification data, complaints, personal and family history, history of the present illness, physical examination, consultations and special examinations, preoperative or pre-treatment diagnosis, operation or treatment, final diagnosis, progress notes, condition on discharge and follow-up. Every record should be a comprehensive word picture of the patient, the illness, and other essential data. It should be an honest, sincere record of facts and conclusions; otherwise it is of little value.

The securing and supervising of records is the responsibility of the physician. The filing of records is usually placed in the hands of a competent clerk. Various systems are utilized in hospitals. Whatever system is used these records should be readily accessible when required in the interest of the patient or the physician.

(6) The hospital shall have an efficient laboratory and x-ray service. Both of these departments are absolutely essential for the carrying out of up-to-date diagnosis and treatment. They should be under the control of competent directors who may have technicians as their assistants. Unreliable laboratory or x-ray service is a serious detriment to any hospital and is decidedly dangerous. For the benefit of the surgical service and to promote good team work between the surgeon, the pathologist, and radiologist, it is advisable that these departments should be within easy access of the operating rooms. There are certain routine and fundamental tests or examinations which every laboratory and x-ray department should be equipped to carry on, and which may be immediately necessary at any time in any hospital. In standardized hospitals, routine pathological examination of all tissues is required in order that there may be a proper check-up on the work.

Development of the Movement

During the past six years, hospitals of 100 beds and over in the United States and Canada have been carefully reviewed. Each year a list of hospitals meeting the minimum standard requirements is published and officially announced at the Clincal Congress of the American College of Surgeons. In addition, during the past two years, hospitals of fifty to 100 beds have been surveyed and those meeting the standard have also been added to the approved list. The progress and development of the movement today is well shown by the following figures taken from the list of approved hospitals between the years 1918 and 1923 inclusive.

During 1923, 1,786 hospitals were surveyed in the United States and Canada. Of these 1,176, or 65.9 per cent, were approved as meeting the minimum standard.

	100 Beds and Over		
Year	Hospitals Surveyed	Hospitals Approved	Percentage
1918	692	89	12.9
1919	692	198	28.6
1920	692	407	58.8
1921	761	573	75.3
1922	812	677	83.4
1923	870	749	86.1
	50 to 100 Beds		
1922	812	335	41.3
1923	916	427	46.7

These figures show conclusively that the medical, the hospital profession, and the public are profoundly interested in the program of hospital betterment. Without the support and cooperation of the above groups, the movement could not have succeeded.

The hospital standardization movement, though still in its youth, has reached maturity in influence and development. It may justly be regarded as one of the greatest hospital movements known in history. The figures quoted show its magnitude and the enormous work associated with its development.

Results of the Movement

Four results of importance may be claimed for this program: (1) the shortening of the patient's days' stay in the hospital; (2) the preventing of any incompetent or unnecessary surgery; (3) the minimizing of the number of infections and complications; and (4) the lowering of the hospital death rate. In regard to the latter, it is very interesting to find that the average hospital death rate, which has been generally from 30, 40, and, in some instances, 50 per thousand patients treated, has been declining in certain institutions which have been operating strictly under the principles laid down by hospital standardization. Many instances show a falling of the death rate down to 30, 20, and even less per thousand patients.

These results have been accomplished through the sincere, honest, conscientious application of the principles as laid down by the college in the program for better hospitals. What a great thing it will be to industry if the days' stay of each industrial patient can be reduced one or two days in each illness. What a great comfort it will be to our people to know that they can go into certain hospitals where their illnesses will be more thoroughly studied and all data recorded, and through this an operation avoided or done under conditions surrounded with the maximum efficiency and safety. What a great thing to the world to find that the former average death rate per thousand patients can be reduced to 30, 20, or lower.

Possibly the greatest accomplishments to stimulate better results is the realization that there must be a physical accounting in our hospitals each month. Each institution should produce a physical balance sheet for the same reasons as there is a financial balance sheet. Both of these statements must be duly audited, the former by the staff for medical auditors, and the second by the financial auditors, or so-called chartered accountants.

The effect of hospital standardization is more or less generally felt throughout the institution. The organization of the medical staff stimulates better organization throughout the hospital. A higher degree of ethics practiced among the attending doctors reacts beneficially

NUMBER OF HOSPITALS MEETING THE MINIMUM STANDARD

United States and Canada	100 or more Beds			50 to 100 Beds			All Hospitals over 50 Beds		
	Number of Hospitals	Approved		Number of Hospitals	Approved		Number of Hospitals	Approved	
		Number	Percentage		Number	Percentage		Number	Percentage
Alabama	10	9	90	14	4	28.6	24	13	54.2
Arizona	2	1	50	2	0	....	4	1	25
Arkansas	5	4	80	10	9	90	15	13	86.7
California	47	34	72.3	29	6	20.7	76	40	52.6
Colorado	13	11	84.6	4	2	50	17	13	76.5
Connecticut	15	14	93.3	8	2	25	23	16	69.6
Delaware	2	2	100	1	0	....	3	2	66.7
District of Columbia	11	9	81.8	2	0	....	13	9	69.2
Florida	6	3	50	8	2	25	14	5	35.7
Georgia	12	9	75	17	8	47	29	17	58.6
Idaho	1	1	100	7	4	57.1	8	5	64.5
Illinois	62	42	67.7	61	21	34.4	123	63	51.2
Indiana	20	14	70	14	8	57.1	34	22	64.7
Iowa	14	12	85.7	27	15	55.6	41	27	65.9
Kansas	6	6	100	25	18	72	31	24	77.4
Kentucky	8	8	100	14	5	35.7	22	13	59.1
Louisiana	7	7	100	10	6	60	17	13	76.5
Maine	5	4	80	10	5	50	15	9	60
Maryland	15	14	93.3	11	6	54.5	26	20	76.9
Massachusetts	44	41	93.2	37	19	51.4	81	60	74.1
Michigan	25	25	100	20	9	45	45	34	75.6
Minnesota	27	27	100	20	9	45	47	36	76.6
Mississippi	5	3	60	8	2	25	13	5	38.5
Missouri	26	24	92.3	22	13	59.1	48	37	77.1
Montana	5	5	100	11	7	63.6	16	12	75
Nebraska	9	8	88.9	15	5	33	24	13	54.2
Nevada	0	..	....	2	2	100	2	2	100
New Hampshire	1	1	100	11	6	54.5	12	7	58.3
New Jersey	35	31	88.6	11	4	36.4	46	35	76.1
New Mexico	0	..	....	4	2	50	4	2	50
New York	120	105	87.5	72	35	48.6	192	140	72.9
North Carolina	5	4	80	21	11	52.4	26	15	57.6
North Dakota	5	5	100	7	2	28.6	12	7	58.3
Ohio	43	42	97.7	28	20	71.4	71	62	87.3
Oklahoma	2	2	100	12	2	16.7	14	4	28.6
Oregon	4	4	100	14	3	21.4	18	7	38.9
Pennsylvania	86	80	93	80	35	43.8	166	115	69.3
Rhode Island	3	3	100	3	2	66.7	6	5	83.3
South Carolina	5	5	100	11	4	36.4	16	9	56.3
South Dakota	4	3	75	12	10	83.3	16	13	81.3
Tennessee	10	9	90	12	7	58.3	22	16	72.7
Texas	21	16	76.2	22	9	40.9	43	25	58.1
Utah	5	5	100	1	1	100	6	6	100
Vermont	1	1	100	5	4	80	6	5	83.3
Virginia	7	6	85.7	28	12	42.9	35	18	51.4
Washington	16	15	93.8	18	4	22.2	34	19	55.9
West Virginia	6	6	100	23	7	30.4	29	13	44.8
Wisconsin	24	17	70.8	27	13	48.1	51	30	58.8
Wyoming	1	..	....	6	2	33.4	7	2	28.6
Totals for U. S.	806	697	86.5	837	382	45.6	1643	1079	65.7
Alberta	7	7	100	4	2	50	11	9	81.8
British Columbia	6	6	100	7	4	57.1	13	10	76.2
Manitoba	6	6	100	2	1	50	8	7	87.5
New Brunswick	1	1	100	9	8	88.9	10	9	90
Nova Scotia	3	3	100	8	8	100	11	11	100
Ontario	25	16	64	30	12	40	55	28	50.9
Prince Edward Island	0	..	....	3	3	100	3	3	100
Quebec	11	9	81.8	9	3	33.4	20	12	60
Saskatchewan	5	4	80	7	4	57.1	12	8	66.7
Totals for Canada	64	52	81.3	79	45	57.7	143	97	68.3
Grand Totals	870	749	86.1	916	427	46.7	1786	1176	65.9

on the nursing staff and interns. Through efficiency, accuracy, and thoroughness on the professional side of the institution, a decided influence along similar lines finds expression in the work of all the other groups. This program undoubtedly establishes an all around spirit of cooperation, rapidly embracing the various groups working in the institution. There is disseminated throughout the spirit of helpfulness, one to another, developing an increasing desire for more communalistic effort than formerly. In a hospital, particularly, we must remember that the various groups working therein cannot carry on without very intimate contact. There is in every hospital an ever present interdependence among the various individuals or groups working therein. There must be provision made for interchange and interaction. In order that there be established the best possible correlation of the various activities for the greatest benefit to the patient, there must be a very highly developed spirit of cooperation.

There is an added stimulus of clinical interest resulting in closer investigation of medical problems, and the advancement of scientific research. The regular staff conference is responsible in great measure for this stimulus. The staff conference brings the doctors together in a group, frequently breaking down local jealousies and always promoting a better spirit of working and consulting together.

Anything that tends to improve the professional atmosphere of the hospital cannot help but have a decided advantage and influence throughout. There, we find that the program of hospital standardization today finds expression in a universal effect on the entire institution, establishing a higher ideal of service and producing a more profound professional consciousness, causing the three groups, namely, the governmental body, the doctors, and the hospital staff, all to work together better for the patient.

Outside of the hospital, the movement is a community interest. People today are seeking the standardized hospital when ill, for they know that the service therein is better administered and supervised. The governments, municipal bodies, and philanthropic organizations make use of the list of approved hospitals when responding to requests for financial assistance. Interns select the approved hospital when furthering their experience. Young women, desiring to take up nursing, also give preference to the approved hospital, knowing that such an institution is better organized and more efficient and can give a more thorough training. In certain instances, state and provincial governments have embodied the principles of hospital standardization in the clauses of their acts when formulating hospital legislation. This movement has been endorsed by a large number of allied organizations of the United States and Canada.

For a period of six years the minimum standard of the American College of Surgeons has been presented to the hospitals of this continent. The general principles of the movement have been well established, and it is now recognized that the important details and further development of the program may safely be undertaken.

There are in connection with the college several committees actively engaged in the study of certain problems relating not only to the various services in our hospitals but as well to the scientific treatment of certain types of patients. The beneficial results obtained from these investigations will be made available for hospitals and should be of inestimable value to them in their advancement.

From time to time requests for information on various subjects are being made to the college. So numerous have these become of late and such is the desire of the college to assist, that it has been found advisable to establish a bureau of information for hospitals. Through this a more extensive and continuous service can be given from headquarters.

The problem of the standardization of the smaller hospitals under fifty beds is being given careful consideration and its solution will be forthcoming in the near future.

Hospital standardization is but in it youth. It has now been proved to be an indispensable factor in increasing the efficiency of hospitals. This movement backed up by a more detailed service from the hospital department of the college will go on from year to year to a much greater attainment even than that which has been established at the present time. The future will, therefore, see a further development of the program and an increased interest and appreciation of the work as all groups directly or indirectly connected with the hospital service are fully convinced of its value to the patient, the doctor, the hospital, and the entire community.

A complete list of approved hospitals from the 1923 survey follows. The work has increased considerably during the year, the magnitude of which can only be realized from the following considerations. There were nine hospital visitors engaged in the field who did sixty months (or five years) of survey work in 1923. The 1786 hospitals visited contained 237,946 beds caring for approximately 4,758,920 patients during the year. The estimated days' treatment for this group is 71,383,800. In the 1176 hospitals which have been accepted as approved there are 191,042 beds caring for approximately 3,820,840 patients with an estimated days' treatment of 57,312,600 for the year. During the survey work the visitors traveled approximately 75,000 miles. Follow-up letters from headquarters numbered over 3500. In addition to all this, thirty-four sectional meetings of the Clinical Congress of the American College of Surgeons were held in various parts of the United States and Canada. At each meeting, an interesting two-day program was provided. A considerable portion of this program on each occasion was devoted to hospital standardization. These meetings throughout were largely attended and fruitful of good results. All the above indicates the opportunity the hospital standardization movement has for extending its beneficial influence.

List of Hospitals

The list which follows is complete up to October 22 of this year. The asterisk indicates that certain hospitals have accepted the requirements which result in the best scientific care of the patients but have not yet, for lack of time or other acceptable reasons, carried them out in every detail.

UNITED STATES

ALABAMA

100 or more beds

*Birmingham Baptist Hospital, Birmingham
Employees' Hospital, T. C. I. R. R. Co., Birmingham
Hillman Hospital, Birmingham
Mobile City Hospital, Mobile
*Moody Hospital, Dotham
Norwood Hospital, Birmingham
Providence Infirmary, Mobile
St. Vincent's Hospital, Birmingham
South Highlands Infirmary, Birmingham

50 to 100 beds

*Alabama Baptist Hospital, Selma
*Frazier Hospital, Dotham
John A. Andrew Memorial Hospital, Tuskegee
Vaughan Memorial Hospital, Selma

ARIZONA

100 or more beds

St. Joseph's Hospital, Phoenix

ARKANSAS

100 or more beds

Logan H. Roots City Memorial Hospital, Little Rock
St. Louis Southwestern R. R. Hospital, Texarkana
St Vincent's Infirmary, Little Rock
Baptist Hospital, Little Rock
Sparks Memorial Hospital, Fort Smith

50 to 100 beds

Baptist Hospital, Little Rock

*Davis Hospital, Pine Bluff
*Fayetteville City Hospital, Fayetteville
Leo N. Levi Memorial Hospital, Hot Springs
Michael Meager Memorial Hospital, Texarkana
St. Bernard's Hospital, Jonesboro
*St. John's Hospital, Fort Smith
*St. Joseph's Hospital, Hot Springs
St. Luke's Hospital and Annex, Little Rock

CALIFORNIA

100 or more beds

Alameda County Hospital, San Leandro
California Lutheran Hospital, Los Angeles
Children's Hospital, Los Angeles
*French Hospital, San Francisco
General Hospital, Fresno
Golden State Hospital, Los Angeles
Hospital for Children, San Francisco
Hospital of the Good Samaritan, Los Angeles
Loma Linda Sanitarium and Hospital, Loma Linda
Los Angeles General Hospital, Los Angeles
Mary's Help Hospital, San Francisco
Methodist Hospital, Los Angeles
Mt. Zion Hospital, San Francisco
*O'Connor Sanitarium, San Jose
Pasadena Hospital, Pasadena
Providence Hospital, Oakland
Sacramento Hospital, Sacramento
*St. Francis' Hospital, San Francisco
*St. Helena Sanitarium, Sanitarium
*St. Joseph's Hospital, San Francisco
St. Joseph's Hospital, San Diego
St. Mary's Hospital, San Francisco
St. Vincent's Hospital, Los Angeles
Samuel Merritt Hospital, Oakland
*San Diego County Hospital, San Diego
San Francisco Hospital, San Francisco
San Joaquin General Hospital, French Camp
Santa Barbara Cottage Hospital, Santa Barbara
Santa Clara County Hospital, San Jose
Seaside Hospital, Long Beach
Southern Pacific Hospital, San Francisco
Stanford University and Lane Hospitals, San Francisco
University of California Hospital, San Francisco
White Memorial Hospital, Los Angeles

50 to 100 beds

Clara Barton Hospital, Los Angeles
Mercy Hospital, Bakersfield
Murphy Memorial Hospital, Whittier
Orthopedic Hospital, Los Angeles
*Paradise Valley Hospital, National City
*Ramona Hospital, San Bernardino

COLORADO

100 or more beds

Beth-El Hospital, Colorado Springs
*Boulder-Colorado Sanitarium, Boulder
Children's Hospital, Denver
Glockner General Hospital, Colorado Springs
Mercy Hospital, Denver
Minnequa Hospital, Pueblo
St. Anthony's Hospital, Denver
St. Francis' Hospital, Colorado Springs
St. Joseph's Hospital, Denver
St. Luke's Hospital, Denver
St. Mary's Hospital, Pueblo

50 to 100 beds

*Denver and Rio Grande Western R. R. Hospital, Salida
*Red Cross Hospital, Salida

CONNECTICUT

100 or more beds

Bridgeport Hospital, Bridgeport
Grace Hospital, New Haven
Greenwich General Hospital, Greenwich
Hartford Hospital, Hartford
*Hospital of St. Raphael, New Haven
Lawrence and Memorial Associated Hospitals, New London
*Meriden Hospital, Meriden
*Middlesex Hospital, Middletown
New Haven Hospital, New Haven
St. Francis' Hospital, Hartford
St. Mary's Hospital, Waterbury
St. Vincent's Hospital, Bridgeport
*Stamford Hospital, Stamford
Waterbury Hospital, Waterbury

50 to 100 beds

New Britain Hospital, New Britain
*Norwalk Hospital, Norwalk

DELAWARE

100 or more beds

*Delaware Hospital, Wilmington
*Homeopathic Hospital, Wilmington

DISTRICT OF COLUMBIA

100 or more beds

*Central Hospital and Dispensary, Washington
*Children's Hospital, Washington
Columbia Hospital for Women, Washington
Freedman's Hospital, Washington
Garfield Memorial Hospital, Washington
George Washington University Hospital, Washington
Georgetown University Hospital, Washington
Providence Hospital, Washington
*Washington Sanitarium and Hospital, Washington

FLORIDA

100 or more beds

Duval County Hospital, Jacksonville
*Miami City Hospital, Miami
St. Luke's Hospital, Jacksonville

50 to 100 beds

*Faith Hospital, St. Petersburg
Gordon Keller Memorial Hospital, Tampa

GEORGIA

100 or more beds

*Davis-Fischer Hospital, Atlanta
Georgia Baptist Hospital, Atlanta
Grady Memorial Hospital, Atlanta
Harbin Hospital, Rome
Piedmont Sanitarium, Atlanta
*St. Joseph's Hospital, Savannah
St. Joseph's Infirmary, Atlanta
University Hospital, Augusta
Wesley Memorial Hospital, Atlanta

50 to 100 beds

*Atlantic Coast Line Hospital, Waycross
*Downey Hospital, Gainesville
*Park View Sanitarium, Savannah
*Savannah Hospital, Savannah
Scottish Rite Hospital, Decatur
*Telfair Hospital, Savannah
*Thomasville City Hospital, Thomasville
Wise Sanitarium, Plains

IDAHO

100 or more beds

St. Alphonsus Hospital, Boise

50 to 100 beds

Pocatello General Hospital, Pocatello
*Providence Hospital, Wallace
*St. Anthony's Hospital, Pocatello
St. Luke's Hospital, Boise

ILLINOIS

100 or more beds

*Alexian Brothers' Hospital, Chicago
Augustana Hospital, Chicago
Chicago Lying-in Hospital, Chicago
Chicago Memorial Hospital, Chicago
Children's Memorial Hospital, Chicago
Columbus Hospital, Chicago
Cook County Hospital, Chicago
Evanston Hospital, Evanston
*Franees E. Willard Hospital, Chicago
*Grant Hospital, Chicago
*Hinsdale Sanitarium, Hinsdale
Hospital of St. Anthony de Padua, Chicago
Illinois Central Hospital, Chicago
Illinois Charitable Eye and Ear Infirmary, Chicago
*Lake View Hospital, Danville
Lutheran Deaconess Hospital, Chicago
*Lutheran Memorial Hospital, Chicago
Mercy Hospital, Chicago
Michael Reese Hospital, Chicago
Misericordia Hospital, Chicago
Mt. Sinai Hospital, Chicago
*Oak Park Hospital, Oak Park
Presbyterian Hospital, Chicago
Rockford Hospital, Rockford
St. Anne's Hospital, Chicago
St. Bernard's Hospital, Chicago
St. Elizabeth's Hospital, Chicago
*St. Elizabeth's Hospital, Danville
St. Francis' Hospital, Blue Island
St. Francis' Hospital, Evanston
St. Francis' Hospital, Peoria
St. Joseph's Hospital, Chicago
*St. Joseph's Hospital, Joliet
St. Luke's Hospital, Chicago
St. Mary's Hospital, East St. Louis
St. Mary's Infirmary, Cairo
*St. Mary's Hospital, Quincy
St. Mary of Nazareth Hospital, Chicago
South Shore Hospital, Chicago
Swedish Covenant Hospital, Chicago
University Hospital, Chicago
Wesley Memorial Hospital, Chicago

50 to 100 beds

*Blessing Hospital, Quincy
*Garfield Park Hospital, Chicago
Huber Memorial Hospital, Pana
Illinois Masonic Hospital, Chicago
*Kewanee Public Hospital, Kewanee
*Lake View Hospital, Chicago
*Lutheran Hospital, Moline
*Moline Public Hospital, Moline
North Chicago Hospital, Chicago
*Olney Sanitarium, Olney
Our Savior's Hospital, Jacksonville
Passavant Memorial Hospital, Jacksonville
*Post-Graduate Hospital, Chicago
*Provident Hospital, Chicago
Ravenswood Hospital, Chicago
St. Andrew's Hospital, Murphysboro
*St. Elizabeth's Hospital, Granite City
*St. Francis' Hospital, Freeport
*St. Francis' Hospital, Kewanee
St. Mary's Hospital, La Salle
Washington Boulevard Hospital, Chicago

INDIANA

100 or more beds

Ft. Wayne Lutheran Hospital, Ft. Wayne
Gary Hospital, Gary
Indianapolis City Hospital, Indianapolis
*Methodist Episcopal Hospital, Indianapolis
*Protestant Deaconess Hospital, Evansville
Robert W. Long Hospital, Indianapolis
St. Anthony's Hospital, Terre Haute
*St. Edward's Hospital, New Albany
St. Elizabeth's Hospital, LaFayette
St. Joseph's Hospital, Ft. Wayne
St. Margaret's Hospital; Hammond
St. Mary's Hospital, Evansville
St. Mary's Mercy Hospital, Gary
*St. Vincent's Hospital, Indianapolis

50 to 100 beds

Epworth Hospital, South Bend
*Grant County Hospital, Marion
Muncie Home Hospital, Muncie
LaFayette Home and Hospital, LaFayette
Reid Memorial Hospital, Richmond
*St. Joseph's Hospital, Logansport
St. Joseph's Hospital, South Bend
Walker Hospital, Evansville

IOWA

100 or more beds

Finley Hospital, Dubuque
Iowa Lutheran Hospital, Des Moines
Iowa Methodist Hospital, Des Moines
Jennie Edmundson Hospital, Council Bluffs
Mercy Hospital, Cedar Rapids
Mercy Hospital, Council Bluffs
Mercy Hospital, Davenport
*Mercy Hospital, Des Moines
St. Joseph's Mercy Hospital, Dubuque
St. Joseph's Mercy Hospital, Sioux City
St. Vincent's Hospital, Sioux City
University Hospital, Iowa City

50 to 100 beds

*Des Moines City Hospital, Des Moines
Iowa Congregational Hospital, Des Moines
Iowa State College Hospital, Ames
Jane Lamb Memorial Hospital, Clinton
Lutheran Hospital, Hampton
Lutheran Hospital, Sioux City
New Samaritan Hospital, Sioux City
*Ottumwa Hospital, Ottumwa
Park Hospital, Mason City
St. Francis' Hospital, Waterloo
*St. Joseph's Hospital, Keokuk
St. Joseph's Hospital, Waverly
St. Joseph's Mercy Hospital, Clinton
St. Joseph's Mercy Hospital, Fort Dodge
St. Joseph's Mercy Hospital, Mason City

KANSAS

100 or more beds

Bethany Methodist Hospital, Kansas City
St. Francis' Hospital, Wichita
St. Margaret's Hospital, Kansas City
Santa Fe Hospital, Topeka
*Wesley Hospital, Wichita
*Wichita Hospital, Wichita

50 to 100 beds

Axtell Hospital, Newton
Bell Memorial Hospital, Kansas City
Bethel Deaconess Hospital, Newton
Halstead Hospital, Halstead
Hutchinson Methodist Hospital, Hutchinson
Jane C. Stormont Hospital, Topeka
*Mercy Hospital, Fort Scott
*Missouri, Kansas, and Texas R. R. Hospital, Parsons
*Mt. Carmel Hospital, Pittsburg
Providence Hospital, Kansas City
St. Anthony's Hospital, Hays
St. Anthony's Mercy Hospital, Sabetha
St. Elizabeth's Hospital, Hutchinson
St. Francis' Hospital, Topeka
St. John's Hospital, Salina
*St. Joseph's Hospital, Concordia
*St. Mary's Hospital, Winfield
St. Rose's Hospital, Great Bend

KENTUCKY

100 or more beds

Good Samaritan Hospital, Lexington
Louisville City Hospital, Louisville
Norton Memorial Hospital, Louisville
St. Anthony's Hospital, Louisville
*St. Elizabeth's Hospital, Covington
Sts. Elizabeth and Mary Hospital, Louisville
St. Joseph's Hospital, Lexington
St. Joseph's Infirmary, Louisville

50 to 100 beds

*Booth Memorial Hospital, Covington
Deaconess Hospital, Louisville
Illinois Central Hospital, Paducah
*Jewish Hospital, Louisville
*Wm. Mason Memorial Hospital, Murray

LOUISIANA

100 or more beds

Charity Hospital, New Orleans
*Charity Hospital, Shreveport
Hotel Dieu, New Orleans
*Presbyterian Hospital, New Orleans
St. Francis' Sanitarium, Munroe
T. E. Schumpert Memorial Hospital, Shreveport
Touro Infirmary, New Orleans

50 to 100 beds

Eye, Ear, Nose and Throat Hospital, New Orleans
*Flint-Goodridge Hospital, New Orleans
Illinois Central R. R. Hospital, New Orleans
North Louisiana Sanitarium, Shreveport
St. Patrick's Sanitarium, Lake Charles
Shriners' Hospital for Crippled Children, Shreveport

MAINE

100 or more beds

*Central Maine General Hospital, Lewiston
General Hospital of St. Marie, Lewiston
Eastern Maine General Hospital, Bangor
*Maine General Hospital, Portland

50 to 100 beds

*Augusta General Hospital, Augusta
Bath City Hospital, Bath
Children's Hospital, Portland

St. Barnabas Hospital, Portland
*State Street Hospital, Portland

MARYLAND

100 or more beds

Allegheny Hospital, Cumberland
Bay View City Hospital Baltimore
Church Home and Infirmary Baltimore
Colonial Hospital, Baltimore
*Franklin Square Hospital, Baltimore
Hebrew Hospital and Asylum, Baltimore
Hospital for Women of Maryland, Baltimore
Johns Hopkins Hospital, Baltimore
Maryland General Hospital, Baltimore
Mercy Hospital, Baltimore
St. Agnes' Hospital, Baltimore
St. Joseph's Hospital, Baltimore
Union Hospital, Baltimore
University Hospital, Baltimore

50 to 100 beds

Children's Hospital School, Baltimore
Emergency Hospital, Easton
Frederick City Hospital, Frederick
James Lawrence Kerman Hospital, Baltimore
*South Baltimore General Hospital, Baltimore
*Western Maryland Hospital, Cumberland

MASSACHUSETTS

100 or more beds

Beverly Hospital, Beverly
Boston City Hospital, Boston
Brockton Hospital, Brockton
Burbank Hospital, Fitchburg
Cambridge City Hospital, Cambridge
Cambridge Hospital, Cambridge
Carney Hospital, Boston
Children's Hospital, Boston
City Hospital, Fall River
Cooley-Dickinson Hospital, Northampton
Free Hospital for Women, Boston
Gale Hospital, Haverhill
Henry Heywood Memorial Hospital, Gardner
Holyoke City Hospital, Holyoke
House of Mercy Hospital, Pittsfield
Lawrence General Hospital, Lawrence
Long Island Hospital, Boston
Lowell Corporation Hospital, Lowell
Lowell General Hospital, Lowell
Lynn Hospital, Lynn
*Malden Hospital, Malden
Massachusetts Charitable Eye and Ear Hospital, Boston
Massachusetts General Hospital, Boston
Massachusetts Homeopathic Hospital, Boston
Memorial Hospital, Worcester
Mercy Hospital, Springfield
New England Hospital for Women and Children, Boston
Newton Hospital, Newton Lower Falls
Noble Hospital, Westfield
Peter Bent Brigham Hospital, Boston
Providence Hospital, Holyoke
St. Elizabeth's Hospital, Boston
St. John's Hospital, Lowell
St. Luke's Hospital, New Bedford
St. Vincent's Hospital, Worcester
Salem Hospital, Salem
Springfield Hospital, Springfield
Union Hospital, Fall River
Waltham Hospital, Waltham
Wesson Memorial Hospital, Springfield
Worcester City Hospital, Worcester

50 to 100 beds

Beth Israel Hospital, Boston
Boston Lying-in Hospital, Boston
Charles Choate Memorial Hospital, Woburn
*Chelsea Memorial Hospital, Chelsea
City Hospital, Quincy
Clinton Hospital, Clinton
Farren Memorial Hospital, Montague City
Faulkner Hospital, Boston
Goddard Hospital, Brockton
Hart Private Hospital, Roxbury
House of the Good Samaritan, Boston
Infant's Hospital, Boston
*Josiah B. Thomas Hospital, Peabody
Melrose Hospital, Melrose
Morton Hospital, Taunton
North Adams Hospital, North Adams
Somerville Hospital, Somerville
Sturdy Memorial Hospital, Attleboro
Truesdale Hospital, Fall River

MICHIGAN

100 or more beds

Battle Creek Sanitarium, Battle Creek
Blodgett Memorial Hospital, Grand Rapids
Butterworth Hospital, Grand Rapids
Children's Free Hospital, Detroit
Detroit Receiving Hospital, Detroit
Evangelical Deaconess Hospital, Detroit
Grace Hospital, Detroit
Edward W. Sparrow Hospital, Lansing
Hackley Hospital, Muskegon
Harper Hospital, Detroit
Henry Ford Hospital, Detroit
Highland Park General Hospital, Highland Park
House of Providence, Detroit
*Hurley Hospital, Flint
Mercy Hospital, Bay City
*Mercy Hospital, Muskegon
New Borgess Hospital, Kalamazoo
Old Borgess Hospital, Kalamazoo
St. Joseph's Mercy Hospital, Ann Arbor
St. Mary's Hospital, Detroit
St. Mary's Hospital, Grand Rapids
*Saginaw General Hospital, Saginaw
University Hospital, Ann Arbor
W. A. Foote Memorial Hospital, Jackson
Woman's Hospital, and Infant's Home, Detroit

50 to 100 beds

Bronson Methodist Hospital, Kalamazoo
Detroit Eye and Ear Hospital, Detroit
Memorial Hospital, Owosso
Mercy Hospital, Jackson
*Nichols Memorial Hospital, Battle Creek
*St. Francis' Hospital, Escanaba
St. Joseph's Hospital, Detroit
St. Joseph's Hospital, Hancock
St. Mary's Hospital, Saginaw

MINNESOTA

100 or more beds

*Abbott Hospital, Minneapolis
Ancker Hospital, St. Paul
Bethesda Hospital, St. Paul
Charles T. Miller Hospital, St. Paul
Colonial Hospital, Rochester
Deaconess Hospital, Minneapolis
Eitel Hospital, Minneapolis
Fairview Hospital, Minneapolis
Kahler Hospital, Rochester
Maternity Hospital, Minneapolis
Minneapolis General Hospital, Minneapolis
Minnesota State Hospital for Indigent Children, Minneapolis
Mounds Park Sanitarium, St. Paul
Northern Pacific Beneficial Association Hospital, St. Paul
Northwestern Hospital, Minneapolis
St. Barnabas Hospital, Minneapolis
St. John's Hospital, St. Paul
St. Josephs' Hospital, St. Paul
St. Luke's Hospital, Duluth
St. Luke's Hospital, St. Paul
St. Mary's Hospital, Minneapolis
St. Mary's Hospital, Duluth
St. Mary's Hospital, Rochester
St. Paul Hospital, St. Paul
Swedish Hospital, Minneapolis
University of Minnesota Hospital, Minneapolis
Worrell Hospital, Rochester

50 to 100 beds

Hill Crest Surgical Hospital, Minneapolis
*Immanuel Hospital, Mankato
*St. Gabriel's Hospital, Little Falls
*St. Joseph's Hospital, Brainerd
*St. Joseph's Hospital, Mankato
*St. Luke's Hospital, Fergus Falls
St. Raphael's Hospital, St. Cloud
Shriners' Hospital for Crippled Children, Minneapolis
*Warren General Hospital, Warren

MISSISSIPPI

100 or more beds

East Mississippi Charity Hospital, Meridian
*Mississippi State Charity Hospital, Jackson
South Mississippi Charity Hospital, Laurel

50 to 100 beds

King's Daughters' Hospital, Gulfport
Mississippi Baptist Hospital, Jackson

MISSOURI

100 or more beds

Alexian Brothers' Hospital, St. Louis
Barnes Hospital, St. Louis
Children's Mercy Hospital, Kansas City
Christian Church Hospital, Kansas City
Evangelical Deaconess Home and Hospital, St. Louis
Frisco Employees Hospital, St. Louis
*Grace Hospital, Kansas City
Jewish Hospital, St. Louis
Kansas City General Hospital, Kansas City
Lutheran Hospital, St. Louis
Missouri Baptist Sanitarium, St. Louis
Missouri Pacific R. R. Hospital, St. Louis
Old General Hospital, Kansas City
Research Hospital, Kansas City
St. Anthony's Hospital, St. Louis
St. John's Hospital, St. Louis
St. Joseph's Hospital, Kansas City
St. Louis Children's Hospital, St. Louis
St. Louis City Hospital, St. Louis
St. Louis Mullanphy Hospital, St. Louis
St. Luke's Hospital, Kansas City
St. Luke's Hospital, St. Louis
St. Mary's Hospital, Kansas City
St. Mary's Infirmary, St. Louis

50 to 100 beds

Baptist Hospital, St. Louis
Barnard Free Skin and Cancer Hospital, St. Louis
Bethesda Hospital, St. Louis
*Boone County Hospital, Columbus
Frisco Employees Hospital, Springfield
Independence Sanitarium, Independence
*Parker Memorial Hospital, Columbia
St. Francis' Hospital, Cape Girardeau
St. Francis' Hospital, Maryville
St. John's Hospital, Joplin
St. Mary's Hospital, Jefferson City
Trinity Lutheran Hospital, Kansas City
University Hospital, Kansas City

MONTANA

100 or more beds

Columbus Hospital, Great Falls
*Holy Rosary Hospital, Miles City
Montana Deaconess Hospital, Great Falls
Murray Hospital, Butte
St. James Hospital, Butte

50 to 100 beds

*Bozeman Deaconess Hospital, Bozeman
*Northern Pacific Beneficial Association Hospital, Glendive
Northern Pacific Beneficial Association Hospital, Missoula
St. Ann's Hospital, Anaconda
St. Joseph's Hospital, Lewiston
St. Patrick's Hospital, Missoula
St. Vincent's Hospital, Billings

NEBRASKA

100 or more beds

Bishop Clarkson Memorial Hospital, Omaha
Nebraska Methodist Episcopal Hospital and Deaconess Home, Omaha
*Nebraska Orthopedic Hospital and Home, Lincoln
St. Elizabeth's Hospital, Lincoln
St. Francis' Hospital, Grand Island
St. Joseph's Hospital, Omaha
St. Mary's Hospital, Columbus
University of Nebraska Hospital, Omaha

50 to 100 beds

Immanuel Hospital, Omaha
*Lincoln Hospital, Lincoln
*Presbyterian Hospital, Omaha
Swedish Mission Hospital, Omaha
Wise Memorial Hospital, Omaha

NEVADA

50 to 100 beds

Elko General Hospital, Elko
St. Mary's Hospital, Reno

NEW HAMPSHIRE

100 or more beds

St. Joseph's Hospital, Nashua

50 to 100 beds

Elliott Community Hospital, Keene
Elliott Hospital, Manchester
Hospital of Notre Dame, Manchester
Mary Hitchcock Memorial Hospital, Hanover
Nashua Memorial Hospital, Nashua
Sacred Heart Hospital, Manchester

NEW JERSEY

100 or more beds

Alexian Brothers' Hospital, Elizabeth
*Atlantic City Hospital, Atlantic City
Bayonne Hospital and Dispensary, Bayonne
Christ Hospital, Jersey City
*Cooper Hospital, Camden
Elizabeth General Hospital, Elizabeth
Englewood Hospital, Englewood
Hackensack Hospital, Hackensack
Hospital of St. Barnabas, Newark
Jersey City Hospital, Jersey City
*Mercer Hospital, Trenton
Monmouth Memorial Hospital, Long Branch
Morristown Memorial Hospital, Morristown
Mountainside Hospital, Montclair
Muhlenberg Hospital, Plainfield
Newark Beth Israel Hospital, Newark
Newark City Hospital, Newark
Newark Memorial Hospital, Newark
Orange Memorial Hospital, Newark
Passaic General Hospital, Passaic
Paterson General Hospital, Paterson
Perth Amboy City Hospital, Perth Amboy
*Presbyterian Hospital, Newark
St. Elizabeth's Hospital, Elizabeth
St. Francis' Hospital, Jersey City
St. Francis' Hospital, Trenton
St. James' Hospital, Newark
*St. Joseph's Hospital, Paterson
*St. Mary's Hospital, Hoboken
*St. Michael's Hospital, Newark
St. Peter's General Hospital, New Brunswick

50 to 100 beds

Ann May Memorial Hospital, Spring Lake
Homeopathic Hospital, Newark
*Middlesex General Hospital, New Brunswick
Nathan and Mariam Barnert Memorial Hospital, Paterson

NEW MEXICO

50 to 100 beds

*St. Joseph's Hospital, Albuquerque
*St. Mary's Hospital, Gallup

NEW YORK

100 or more beds

Albany Hospital, Albany
*Arnot-Ogden Memorial Hospital, Elmira
Auburn City Hospital, Auburn
Bellevue Hospital, New York
*Beth David Hospital, New York
Beth Israel Hospital, New York
Beth Moses Hospital, Brooklyn
Binghamton Hospital, Binghamton
Broad Street Hospital, New York
*Bronx Hospital, New York
Brooklyn Hospital, Brooklyn
Brownsville and East New York Hospital, Brooklyn
Buffalo City Hospital, Buffalo
Buffalo General Hospital, Buffalo
Buffalo Homeopathic Hospital, Buffalo
Buffalo Hospital of Sisters of Charity, Buffalo
Bushwick Hospital, Brooklyn
Carson C. Peck Memorial Hospital, Brooklyn
Children's Hospital, Buffalo
Columbus Extension Hospital, New York

Community Hospital, New York
Coney Island Hospital, Brooklyn
Cumberland Street Hospital, Brooklyn
Deaconess Home and Hospital, Buffalo
Ellis Hospital, Schenectady
Faxton Hospital, Utica
Fifth Avenue Hospital, New York
Flower Hospital, New York
Flushing Hospital and Dispensary, Flushing
Fordham Hospital, New York
French Benevolent Society Hospital, New York
Gouverneur Hospital, New York
Greenpoint Hospital, Brooklyn
Harlem Hospital, New York
Highland Hospital, Rochester
Holy Family Hospital, Brooklyn
Homeopathic Hospital, Albany
House of the Good Samaritan, Watertown
Hospital of the Good Shepherd, Syracuse
*Ithaca City Hospital, Ithaca
Jewish Hospital, Brooklyn
King's County Hospital, Brooklyn
Knickerbocker Hospital, New York
Lebanon Hospital, New York
Lenox Hill Hospital, New York
Lincoln Hospital, New York
Long Island College Hospital, Brooklyn
Manhattan Eye and Ear Hospital, New York
Memorial Hospital for Cancer and Allied Diseases, New York
Methodist Episcopal Hospital, Brooklyn
Metropolitan Hospital, New York
Misericordia Hospital, New York
Montefiore Hospital, New York
Mt. Sinai Hospital, New York
Mt. St. Mary's Hospital, Niagara Falls
Mt. Vernon Hospital, Mt. Vernon
New York City Hospital, Blackwell's Island, New York
*New York Eye and Ear Infirmary, New York
New York Foundling Home, New York
New York Hospital, New York
New York Infirmary for Women and Children, New York
New York Nursery and Children's Hospital, New York
New York Orthopedic Hospital, New York
New York Post-Graduate Hospital, New York
*New York Skin and Cancer Hospital, New York
New York Society for Relief of the Ruptured and Crippled, New York
*New York State Orthopedic Hospital for Children, West Haverstraw
Niagara Falls Memorial Hospital, Niagara Falls
Norwegian Lutheran Deaconess Hospital, Brooklyn
*Olean General Hospital, Olean
Oneida County Hospital, Rome
Park Avenue Clinical Hospital, Rochester
Presbyterian Hospital, New York
*Prospect Heights Hospital and Maternity, Brooklyn
Rochester General Hospital, Rochester
Rochester Homeopathic Hospital, Rochester
Roosevelt Hospital, New York
St. Catherine's Hospital, Brooklyn
*St. Elizabeth's Hospital and Home, Utica
St. Francis' Hospital, New York
St. John's Brooklyn Hospital, Brooklyn
St. John's Hospital, Long Island
St. John's Riverside Hospital, Yonkers
*St. Joseph's Hospital, Syracuse
St. Luke's Hospital, New York
*St. Luke's Hospital, Utica
St. Mark's Hospital, New York
St. Mary's Free Hospital for Children, New York
St. Mary's Hospital, Brooklyn
St. Mary's Hospital, Rochester
St. Peter's Hospital, Albany
St. Peter's Hospital, Brooklyn
St. Vincent's Hospital, New York
Samaritan Hospital, Troy
Sloane Hospital for Women, New York
*Soldiers and Sailors Memorial Hospital, Utica
Staten Island Hospital, Tompkinsville
Syracuse Memorial Hospital, Syracuse
The Sanitarium, Clifton Springs
Troy Hospital, Troy
*United Hospital, Port Chester
*United Israel Zion Hospital, Brooklyn
Women's Hospital, New York
Wyckoff Heights Hospital, Brooklyn
Yonker's Homeopathic Hospital and Maternity, Yonkers

50 to 100 beds

Amsterdam City Hospital, Amsterdam
Anthony Brady Hospital, Albany
Babies Hospital, New York
*Beekman Street Hospital, New York
*Broad Street Hospital, Oneida
*Brooks Memorial Hospital, Dunkirk
*Buffalo Columbus Hospital, Buffalo
*Champlain Valley Hospital, Plattsburg
Columbus Hospital, New York
Emergency Hospital of Sisters of Charity, Buffalo
General Hospital, Syracuse
Geneva City Hospital, Geneva
Glens Falls Hospital, Glens Falls
*Harbor Hospital, Brooklyn
Hudson City Hospital, Hudson
Jamaica Hospital, Jamaica
Jewish Maternity Hospital, New York
Kingston City Hospital, Kingston
Lawrence Hospital, Bronxville
*Leonard Hospital, Troy
Mary Immaculate Hospital, Jamaica
Mary McClelland Hospital, Cambridge
*Nassau Hospital, Mineola, Long Island
*Nathan Littauer Hospital, Gloversville
New Rochelle Hospital, New Rochelle
Ossining Hospital, Ossining
Peoples Hospital, New York
Reconstruction Hospital, New York
Rome Hospital, Rome
St. Bartholomew's Hospital, New York
*St. Joseph's Hospital, Yonkers
St. Vincent's Hospital, West New Brighton
Saratoga Hospital, Saratoga Springs
*Swedish Hospital, Brooklyn
*White Plains Hospital, White Plains

NORTH CAROLINA

100 or more beds

*James Walker Memorial Hospital, Wilmington
*North Carolina Baptist Hospital, Winston-Salem
*St. Leo's Hospital, Greensboro
Watts Hospital, Durham

50 to 100 beds

Atlantic Coast Lines R. R. Hospital, Rocky Mount
Charlotte Sanitarium, Charlotte
City Hospital, Winston-Salem
Highpoint Hospital, Highpoint
Highsmith Hospital, Fayetteville
*Long's Sanitarium, Statesville
*Mercy Hospital, Charlotte
Parkview Hospital, Rocky Mount
*Rex Hospital, Raleigh
Rutherfordton Hospital, Rutherfordton
Salisbury Hospital, Salisbury

NORTH DAKOTA

100 or more beds

Bismarck Evangelical Deaconess Hospital, Bismarck
Grand Forks Deaconess Hospital, Grand Forks
St. Alexius' Hospital, Bismarck
St. John's Hospital, Fargo
St. Luke's Hospital, Fargo

50 to 100 beds

*St. Joseph's Hospital, Minot
St. Michael's Hospital, Grand Forks

OHIO

100 or more beds

Aultman Hospital, Canton
Bethesda Hospital, Cincinnati
Christ Hospital, Cincinnati
Cincinnati General Hospital, Cincinnati
City Hospital of Akron, Akron
Cleveland City Hospital, Cleveland
Glenville Hospital, Cleveland
Good Samaritan Hospital, Cincinnati
*Good Samaritan Hospital, Zanesville
Grant Hospital, Columbus
Hawkes Hospital of Mt. Carmel, Columbus
Huron Road Hospital, Cleveland
Jewish Hospital, Cincinnati
Lakeside Hospital, Cleveland
Lima Hospital, Lima
Lucas County Hospital, Toledo
*Lutheran Hospital, Cleveland
Mercy Hospital, Canton
Mercy Hospital, Hamilton
Mercy Hospital, Toledo
Miami Valley Hospital, Dayton
Mt. Sinai Hospital, Cleveland
*Peoples Hospital, Akron
St. Alexis' Hospital, Cleveland
St. Ann's Infant Asylum and Hospital, Cleveland
St. Elizabeth's Hospital, Dayton
St. Elizabeth's Hospital, Youngstown
St. Francis' Hospital, Columbus
St. John's Hospital, Cleveland
*St. Joseph's Hospital, Lorain
St. Luke's Hospital, Cleveland
St. Mary's Hospital, Cincinnati
St. Rita's Hospital, Lima
St. Vincent's Hospital, Cleveland
St. Vincent's Hospital, Toledo
*Seton Hospital, Cincinnati
Springfield City Hospital, Springfield
Toledo Hospital, Toledo
University Homeopathic Hospital, Columbus
*White Cross Hospital, Columbus
*Woman's Hospital, Cleveland
Youngstown Hospital, Youngstown

50 to 100 beds

Alliance City Hospital, Alliance
Bellaire City Hospital, Bellaire
*Bethesda Hospital, Zanesville
Children's Hospital, Cincinnati
Children's Hospital, Columbus
Deaconess Hospital, Cincinnati
Flower Hospital, Toledo
Good Samaritan Hospital, Sandusky
Lakewood Hospital, Lakewood
Mary Day Nursery and Children's Hospital, Akron
Massillon City Hospital, Massillon
Maternity and Children's Hospital, Toledo
Maternity Hospital, Cleveland
*Memorial Hospital, Fremont
Mercy Hospital, Columbus
Newark City Hospital, Newark
Robinwood Hospital, Toledo
Salem Hospital, Salem
Schirrman Hospital, Portsmouth
Warren City Hospital, Warren

OKLAHOMA

100 or more beds

St. Anthony's Hospital, Oklahoma City
State University Hospital, Oklahoma City

50 to 100 beds

*El Reno Sanitarium, El Reno
*Wesley Hospital, Oklahoma City

OREGON

100 or more beds

Emmanuel Hospital, Portland
Good Samaritan Hospital, Portland
Multnomah County Hospital, Portland
St. Vincent's Hospital, Portland

50 to 100 beds

Portland Sanitarium, Portland
Portland Surgical Hospital, Portland
*Sacred Heart Hospital, Medford

PENNSYLVANIA

100 or more beds

Abingdon Memorial Hospital, Abingdon
Allegheny General Hospital, Pittsburgh
Allentown Hospital, Allentown
Altoona Hospital, Altoona
Braddock General Hospital, Braddock
Chester County Hospital, West Chester
*Chester Hospital, Chester
Chestnut Hill Hospital, Philadelphia
Children's Homeopathic Hospital, Philadelphia
Children's Hospital, Pittsburgh
Clearfield Hospital, Clearfield
Columbia Hospital, Pittsburgh
Conemaugh Valley Memorial Hospital, Johnstown
Easton Hospital, Easton
Elizabeth Steel Magee Hospital, Pittsburgh
Frankford Hospital, Philadelphia
George F. Geisinger Hospital, Danville
Germantown Dispensary and Hospital, Philadelphia
Hahnemann Hospital, Scranton
Hahnemann Medical and Surgical Hospital, Philadelphia
Hamot Hospital, Erie
Harrisburg Hospital, Harrisburg
Homeopathic Medical and Surgical Hospital, Pittsburgh
Hospital of the Protestant Episcopal Church, Philadelphia
Hospital of the University of Pennsylvania, Philadelphia
Hospital of the Women's Medical College, Philadelphia
*J. Lewis Crozer Home and Hospital, Chester
Jefferson Hospital, Philadelphia
Jewish Hospital, Philadelphia
*Kane Summitt Hospital, Kane
Lancaster General Hospital, Lancaster
Lankenau Hospital, Philadelphia
*McKeesport Hospital, McKeesport
Medico Chirurgical Hospital, Philadelphia
Memorial Hospital, Roxborough
Mercy Hospital, Johnstown
Mercy Hospital, Philadelphia,
Mercy Hospital, Pittsburgh
Mercy Hospital, Wilkes-Barre
Methodist Episcopal Hospital, Philadelphia
Misericordia Hospital, Philadelphia
Moses Taylor Hospital, Scranton
Mt. Sinai Hospital, Philadelphia
Passavant Hospital, Pittsburgh
Pennsylvania Hospital, Philadelphia
Philadelphia General Hospital, Philadelphia
Philadelphia Polyclinic Hospital, Philadelphia
Pittsburgh Hospital, Pittsburgh
Pottsville Hospital, Pottsville
Presbyterian Hospital, Philadelphia
Presbyterian Hospital, Pittsburgh
Reading Hospital, Reading
Robert Packer Hospital, Sayre
Sacred Heart Hospital, Allentown
St. Agnes' Hospital, Philadelphia
St. Francis' Hospital, Pittsburgh
St. John's General Hospital, Pittsburgh
St. Joseph's Hospital, Lancaster
*St. Joseph's Hospital, Philadelphia
St. Joseph's Hospital, Pittsburgh
St. Joseph's Hospital, Reading
St. Luke's Hospital, South Bethlehem
St. Margaret's Hospital, Pittsburgh
St. Mary's Hospital, Philadelphia
St. Vincent's Hospital, Erie
Samaritan Hospital, Philadelphia
South Side Hospital, Pittsburgh
State Hospital for Injured Persons, Ashland
State Hospital of Middle Coal Fields, Hazelton
State Hospital of Northern Anthracite Region of Pennsylvania, Scranton
Uniontown Hospital, Uniontown
Washington Hospital, Washington
West Philadelphia Hospital for Women, Philadelphia
Western Pennsylvania Hospital, Pittsburgh
Wilkes-Barre City Hospital, Wilkes-Barre

*Williamsport Hospital, Williamsport
Wills Hospital, Philadelphia
Women's Homeopathic Hospital, Philadelphia
Women's Hospital, Philadelphia
York Hospital and Dispensary, York

50 to 100 beds

Annie M. Warner Hospital, Gettysburg
Bainbridge Private Hospital, Philadelphia
Bryn Mawr Hospital, Bryn Mawr
Carlisle Hospital, Carlisle
Children's Hospital, Philadelphia
Children's Hospital of Mary J. Drexel Home, Philadelphia
Citizens General Hospital, New Kensington
*Columbia Hospital, Columbia
Cottage State Hospital, Blossburg
*DuBois Hospital, DuBois
Good Samaritan Hospital, Lebanon
Howard Hospital, Philadelphia
*Homeopathic Hospital, West Chester
Indiana Hospital, Indiana
J. C. Blair Memorial Hospital, Huntington
*Jewish Maternity Hospital, Philadelphia
Kensington Hospital for Women, Philadelphia
Maple Avenue Hospital, DuBois
*Memorial Hospital of Monongahela, Monongahela
*Montefiore Hospital, Pittsburgh
*Ohio Valley Hospital, McKees Rock
Oil City Hospital, Oil City
Palmerton Hospital, Palmerton
Philadelphia Lying-in Charity Hospital, Philadelphia
*Pittston Hospital, Pittston
*Polyclinic Hospital, Harrisburg
Preston Retreat Hospital
Preston Retreat Hospital, Philadelphia
*Providence Hospital, Beaver Falls
St. Luke's Homeopathic Hospital, Philadelphia
St. Vincent's Hospital for Women and Children, Philadelphia
*Sewickley Hospital, Sewickley
*State Hospital of Nanticoke, Nanticoke
*Stetson Hospital, Philadelphia
Suburban General Hospital, Bellevue
Windber Hospital, Windber

RHODE ISLAND

100 or more beds

Newport Hospital, Newport
Rhode Island Hospital, Providence
St. Joseph's Hospital, Providence

50 to 100 beds

Memorial Hospital, Pawtucket
Providence Lying-in Hospital, Providence

SOUTH CAROLINA

100 or more beds

Columbia Hospital, Columbia
Florence Infirmary, Florence
Greenville City Hospital, Greenville
Roper Hospital, Charleston
South Carolina Baptist Hospital, Columbia

50 to 100 beds

Anderson County Hospital, Anderson
Baker County Hospital, Charleston
St. Francis Xavier Infirmary, Charleston
*University Hospital, Anderson

SOUTH DAKOTA

100 or more beds

McKennan Hospital, Sioux Falls
*Sacred Heart Hospital, Yankton
St. Luke's Hospital, Aberdeen

50 to 100 beds

Bartron Hospital, Watertown
Lincoln Hospital, Aberdeen
Luther Hospital, Watertown
*Moe Hospital, Sioux Falls
New Madison Hospital, Madison
Methodist State Hospital, Mitchell
*Peabody Hospital, Webster
*St. Joseph's Hospital, Deadwood
*St. Joseph's Hospital, Mitchell
St. Mary's Hospital, Pierre

TENNESSEE

100 or more beds

Baptist Hospital, Memphis
Erlanger Hospital, Chattanooga
George W. Hubbard Hospital, Nashville
Knoxville General Hospital, Knoxville
Memphis General Hospital, Memphis
Nashville City Hospital, Nashville
St. Joseph's Hospital, Memphis
St. Thomas Hospital, Nashville
Vanderbilt Hospital, Nashvillle

50 to 100 beds

Baird-Dulaney Hospital, Dyersburg
*Fort Sanders Hospital, Knoxville
Lucy Brinkley Hospital, Memphis
Newell and Newell Sanitarium, Chattanooga
*Protestant Hospital, Nashville
*Riverside Hospital, Knoxville
Women's Hospital of State of Tennessee, Nashville

TEXAS

100 or more beds

Baptist Hospital, Houston
Baylor Hospital, Dallas
Central Texas Baptist Sanitarium, Waco
Hotel Dieu, Beaumont
John Sealy Hospital, Galveston
Parkland Hospital, Dallas
Providence Hospital, Waco
St. Joseph's Infirmary, Ft. Worth
St. Joseph's Infirmary, Houston
St. Mary's Infirmary, Galveston
St. Paul's Sanitarium, Dallas
Santa Fe Hospital, Temple
Santa Rosa Infirmary, San Antonio
Scott and White Sanitarium, Temple
Seton Infirmary, Austin
Southern Pacific Hospital, Houston

50 to 100 beds

All Saint's Hospital, Ft. Worth
*City and County Hospital, Houston
*Frances Ann Lutcher Hospital, Orange
Harris Sanitarium, Ft. Worth
International and Great Northern R. R. Hospital, Palestine
King's Daughters' Hospital, Temple
*Masonic Hospital, El Paso
*St. Joseph's Infirmary, Paris
*Texarkana Sanitarium, Texarkana

UTAH

100 or more beds

Doctor W. H. Groves Latter Day Saints' Hospital, Salt Lake City
Holy Cross Hospital, Salt Lake City
St. Mark's Hospital, Salt Lake City
Salt Lake County Hospital, Salt Lake City
Thomas D. Dee Memorial Hospital, Ogden

50 to 100 beds

Utah-Idaho Hospital, Logan

VERMONT

100 or more beds

Mary Fletcher Hospital, Burlington

50 to 100 beds

Fanny Allen Hospital, Winooski
Heaton Hospital, Montpelier
Rutland Hospital, Rutland
*St. Albans Hospital, St. Albans

VIRGINIA

100 or more beds

Chesapeake and Ohio R. R. Hospital, Clifton Forge
*Hospital Division of Medical College of Virginia, Richmond
Norfolk Protestant Hospital, Norfolk
St. Vincent's Hospital, Norfolk
Stuart Circle Hospital, Richmond
University of Virginia Hospital, Charlottesville
Elizabeth Buxton Hospital, Newport News

50 to 100 beds

George Ben Johnson Memorial Hospital, Abingdon
*Grace Hospital, Richmond
Jefferson Hospital, Roanoke
Johnston-Willis Sanitarium, Richmond
King's Daughters' Hospital, Staunton
Lake View Hospital, Suffolk
Lewis Gale Hospital, Roanoke
*Parrish Memorial Hospital, Portsmouth
St. Elizabeth's Hospital, Richmond
St. Luke's Hospital, Richmond
Sarah Leigh Hospital, Norfolk

WASHINGTON

100 or more beds

Children's Orthopedic Hospital, Seattle
Columbus Sanitarium, Seattle
King County Hospital, Seattle
Maria Beard Deaconess Hospital, Spokane
*Northern Pacific Hospital, Tacoma
Providence Hospital, Seattle
Sacred Heart Hospital, Spokane
St. Elizabeth's Hospital, Yakima
St. Joseph's Hospital, Tacoma
St. Luke's Hospital, Spokane
St. Mary's Hospital, Walla Walla
Seattle City Hospital, Seattle
Seattle General Hospital, Seattle
Swedish Hospital, Seattle
Tacoma General Hospital, Tacoma

50 to 100 beds

Minor Private Hospital, Seattle
*St. Joseph's Hospital, Bellingham
St. Luke's Hospital, Seattle
Virginia Mason Hospital, Seattle

WEST VIRGINIA

100 or more beds

Charleston General Hospital, Charleston
Kessler Hatfield Hospital, Huntington
Ohio Valley Hospital, Wheeling
St. Mary's Hospital, Clarksburg
Welch Hospital, No. 1, Welch
Wheeling Hospital, Wheeling

50 to 100 beds

*Beckley Hospital, Beckley
Bluefield Sanitarium, Bluefield
Coal Valley Hospital, Montgomery
Cook Hospital, Fairmont
Davis Memorial Hospital, Elkins
Guthrie Hospital, Huntington
McKendree Hospital, No. 2, McKendree

WISCONSIN

100 or more beds

LaCrosse Lutheran Hospital, LaCrosse
Luther Hospital, Eau Claire
Madison General Hospital, Madison
Mercy Hospital, Janesville
Milwaukee County Hospital, Milwaukee
Milwaukee Hospital, Milwaukee
Mt. Sinai Hospital, Milwaukee
St. Agnes' Hospital, Fond du Lac
St. Elizabeth's Hospital, Appleton
St. Francis Hospital, LaCrosse
St. Joseph's Hospital, Marshfield
St. Joseph's Hospital, Milwaukee
*St. Mary's Hospital, Green Bay
St. Mary's and Mercy Hospital, Oshkosh
St. Mary's Hospital, Superior
Trinity Hospital, Milwaukee

100 or more beds

*Columbia Hospital, Milwaukee
Evangelical Deaconess Hospital, Milwaukee
Grandview Hospital, LaCrosse
*Hanover General Hospital, Milwaukee
*Holy Family Hospital, Manitowoc
*LaCrosse Public Hospital, LaCrosse
Milwaukee Children's Hospital, Milwaukee
*Milwaukee Maternity and General Hospital, Milwaukee
Misericordia Hospital, Milwaukee
St. Joseph's Hospital, Dodgeville
*St. Luke's Hospital, Racine
St. Mary's Hospital, Madison
St. Mary's Hospital, Racine

WYOMING

100 or more beds

*Casper Private Hospital, Casper
Wheatland Hospital, Wheatland

CANADA

ALBERTA

100 or more beds

General Hospital, Calgary
Edmonton General Hospital, Edmonton
Holy Cross Hospital, Calgary
Medicine Hat Hospital, Medicine Hat
Misericordia Hospital, Edmonton
Royal Alexandra Hospital, Edmonton
University of Alberta Hospital, Edmonton

50 to 100 beds

Lamont Public Hospital, Lamont
*Galt Hospital, Lethbridge

BRITISH COLUMBIA

100 or more beds

Provincial Royal Jubilee Hospital, Victoria
Royal Columbian Hospital, New Westminster
Royal Inland Hospital, Kamloops
St. Joseph's Hospital, Victoria
St. Paul's Hospital, Vancouver
Vancouver General Hospital, Vancouver

50 to 100 beds

*Queen Victoria Hospital, Revelstoke
*St. Eugene Hospital, Cranbrook
*St. Mary's Hospital, New Westminster
*Vernon Jubilee Hospital, Vernon

MANITOBA

100 or more beds

Brandon General Hospital, Brandon
Children's Hospital, Winnipeg
Grace Hospital, Winnipeg
Misericordia Hospital, Winnipeg
St. Boniface's Hospital, St. Boniface
Winnipeg General Hospital, Winnipeg

50 to 100 beds

Victoria Hospital, Winnipeg

NEW BRUNSWICK

100 or more beds

General Public Hospital, St. John

50 to 100 beds

Chipman Memorial Hospital, St. Stephen
Hotel Dieu, Campbellton
Hotel Dieu, Chatham
Miramichi Hospital, New Castle
Moncton Hospital, Moncton
St. John's Infirmary, St. John
Restigouche and Bay of Chaleur Soldiers' Memorial Hospital, Campbellton
*Victoria Public Hospital, Fredericton

NOVA SCOTIA

100 or more beds

St. Joseph's Hospital, Glace Bay
Salvation Army Hospital, Halifax
Victoria General Hospital, Halifax

50 to 100 beds

*Aberdeen Hospital, New Glasgow
Children's Hospital, Halifax
General Hospital, Glace Bay
Halifax Infirmary, Halifax
Highland View Hospital, Amherst
St. Martha's Hospital, Antigonish
*Sydney City Hospital, Sydney
*Yarmouth Hospital, Yarmouth

ONTARIO

100 or more beds

General Hospital, Kingston
Grace Hospital, Toronto
Hamilton General Hospital, Hamilton
Hotel Dieu, Kingston
McKellar General Hospital, Ft. William
Ottawa General Hospital, Ottawa
Protestant General Hospital, Ottawa
St. Joseph's Hospital, Hamilton
*St. Joseph's Hospital, London
St. Joseph's Hospital, Sudbury
St. Luke's Hospital, Ottawa
St. Michael's Hospital, Toronto
Sick Children's Hospital, Toronto
Toronto General Hospital, Toronto
Western Hospital, Toronto
Victoria Hospital, London

50 to 100 beds

*General Hospital, Brockville
General Hospital, Sault Ste. Marie
Nicholls Hospital, Peterboro
Oshawa Memorial Hospital, Oshawa
*Owen Sound General and Marine Hospital, Owen Sound

*Public Hospital, Smith Falls
*St. Francis' Hospital, Smith Falls
St. Joseph's Hospital, Peterboro
St. Vincent de Paul Hospital, Brockville
Welland County Hospital, Welland
Wellesley Hospital, Toronto
Women's College Hospital, Toronto

PRINCE EDWARDS ISLAND

50 to 100 beds

Charlottetown Hospital, Charlottetown
*Prince County Hospital, Summerside
Prince Edward Island Hospital, Charlottetown

QUEBEC

100 or more beds

Children's Memorial Hospital, Montreal
General St. Vincent Hospital, Sherbrooke
Hotel Dieu, Montreal
Jeffery Hale's Hospital, Quebec
Montreal General Hospital, Montreal
Notre Dame Hospital, Montreal
Sainte Justine Pour Les Enfants, Montreal
Royal Victoria Hospital, Montreal
Western Hospital, Montreal

50 to 100 beds

Montreal Maternity Hospital, Montreal
St. Francois d'Assise, Quebec
*Sherbrooke Hospital, Sherbrooke

SASKATCHEWAN

100 or more beds

Grey Nuns Hospital, Regina
Providence Hospital, Moose Jaw
St. Paul's Hospital, Saskatoon
*Saskatoon City Hospital, Saskatoon

50 to 100 beds

Holy Family Hospital, Prince Albert
Notre Dame Hospital, North Battleford
*Moose Jaw General Hospital, Moose Jaw
*Victoria Hospital, Prince Albert

INTEREST CENTERS AROUND "STANDARDIZATION" AT A. C. OF S. HOSPITAL CONFERENCE

SURGEONS from all parts of the country, from the Canadian provinces, Mexico, Cuba, South America, and England to the number of 3,000 in addition to hospital officials, attended the hospital sessions of the thirteenth annual clinical congress of the American College of Surgeons held at the Congress Hotel, October 22 and 23, 1923.

The two days' hospital conference centered around hospital standardization which, as Dr. Malcolm T. MacEachern, associate director of the college, hospital activities, says is the most far reaching movement ever undertaken by that organization. It is one which is revolutionizing the modern hospital, and every hospital no matter how large or small is directly affected by the movement.

The morning session of the congress, October 22, was opened with an address by Dr. Franklin H. Martin, director general of the college, who briefly reviewed the standardization work of the college and outlined what had been accomplished and the present status of the work. "In the beginning," said Dr. Martin, "the work was undertaken as a purely selfish one by which the fellows of the college could be selected, but it has grown to be one which has touched every phase of the medical profession in its attempt to make the hospital a fit workshop for its workers, the surgeons of this continent."

Status of the Movement

Following the address of Dr. Martin, Dr. MacEachern gave a brief summary of the 1923 survey, (a report of which may be found on page 518 of this issue) pointing out the problems of the future. In concluding, he said that it had taken six years to survey the 100-bed hospitals and that as yet only two years had been spent in the survey of the fifty bed hospitals, leaving a large portion of the work yet to be accomplished.

Dr. Allen Craig, associate director of the college, provincial activities, spoke upon the approved hospital as a factor in advancing scientific medicine pointing out what the hospital and patient could do in contributing to medical science. Dr. Craig looked to the day when every standardized hospital would offer a definite contribution to medical science.

The Small Hospital's Part

Dr. John B. McKenzie, Logieville, N. B., talked upon "Hospital Standardization and the Community Hospital," with special reference to the smaller hospitals of the Canadian provinces with which he is particularly acquainted. Dr. McKenzie showed the progress which the small hospitals of New Brunswick had made as a result of the standardization movement. He said that before the era of standardization follow-up work was unknown to these hospitals and that the work of the college in Canada has been outstanding in the way of producing better study of cases, better group surgery, better educated doctors and better cooperation within and outside the hospital. Dr. McKenzie pleaded for the college to use more publicity in its work in the smaller communities of the Canadian provinces.

Nursing's Share in the Movement

"A Review of the Present Status of Nursing in the United States and Canada," was presented by Miss Isabel Stewart, R.N., assistant professor of nursing, Columbia University, New York, N. Y. Miss Stewart traced the development of the nursing profession and presented the problems now confronting the profession from the viewpoint of the nurse. She drew special attention to the fact that, up to the present, the education of the nurse, her intellectual and social development, has been almost entirely subordinated to routine work for the hospital's economic benefit. Miss Stewart showed that even now one-fourth to one-fifth of the students time is spent in menial work which has tended to humiliate the nurse and prevent her from making intellectual advancement in her profession. She pleaded for a lessening of the autocratic regime which subordinates the nurse and a more intelligent cooperation between doctor and nurse. She also stressed the need of increased educational requirement and expressed the hope of a greater number of endowed schools.

Miss Jean E. Browne, R.N., president, Canadian National Association of Trained Nurses, Toronto, Ont., spoke upon the same subject from the viewpoint of the Canadian nurse. Miss Browne briefly described the system of nurses' training in the provinces and the recent development of district nursing and of the nursing housekeeper in community work. She directed attention to the increased tendency toward consolidation in the teaching of nursing in Toronto where the students from all schools assemble and have their lectures together. She showed that the three big problems confronting nursing in Canada are: (1) better schemes of affiliation between general and special hospitals: (2) extension of nursing housekeepers; (3) standardization which implies a minimum national standard curriculum.

Moral Aspect of Standardization

"Hospital Standardization and the Medical and Nursing Profession," was the subject of a brief address made by the Rev. C. B. Moulinier, president, Catholic Hos-

pital Association, Milwaukee, Wis. Father Moulinier emphasized the moral obligation which the minimum standard places upon not only the hospital as an organized body, but upon each individual physician, nurse and hospital employee in carrying out the regulations which the minimum standard places upon them. Father Moulinier said that the greatest obstacle to standardization is personal gain which has shown itself in such measures as fee-splitting. "The three things which are needed to make standardization a success are wisdom, justice, and a moderation of selfish interests," said Father Moulinier. "There is too much greed in hospitals as well as other enterprises of today."

The concluding address of the morning session was given by Robert Jolly, superintendent, Baptist Hospital, Houston, Texas, who spoke upon "The Care of the Patient in the Standardized Versus the Non-standardized Hospital." Mr. Jolly said that the difference between the two institutions, as far as protection to the patient is concerned, was the difference between living in an insured house and a non-insured house. He showed that the increased examination of the patient which standardization requires of the hospital was a guarantee of protection to the patient which could not be overestimated, and that standardization has produced invaluable results in the way of straightening hospital records, in the way of injecting life into the board and staff meetings, and in the increased efficiency of the management of the institution.

Follow-up Work of Surgeon

The afternoon session was divided between four papers and a round table discussion of topics of vital interest to hospitals. "The Value and Need of More Attention to End-Results and Follow-up in Hospitals Today" was the subject of a paper by Dr. George Gray Ward, chief surgeon, Woman's Hospital New York, N. Y.

Dr. Ward stressed the necessity of the surgeon himself doing the follow-up work, and the need for more improved methods of carrying on such work. He also dwelt upon the necessity of careful auditing of surgical results and the development of a surgical conscience.

This was followed by a paper on "The Registry of Bone Sarcoma as an Example of the End-Result Idea in Hospital Organization," by Dr. Ernest A. Codman, Boston, chairman, committee on registry of bone sarcoma, of the college. Dr. Codman said that real bone sarcoma is very rare and that, for this reason, it is not recognized and is mistreated by Dr. "Wisdoms" who confine themselves to individual diagnoses. He pointed out that careful recording is the only way that progress will be made in this disease.

"A Scheme for Surgical Rating," was the subject of a paper by Dr. Ernest Leroi Hunt, surgeon and director, Worcester City Hospital, Worcester, Mass. Dr. Hunt showed the need for a scheme for rating cases and the need for follow-up clinics. He pointed out that this would result in better surgeons, the lessening of recurrences, and a valuable storehouse of knowledge for the staff through the data gathered.

Problem of Providing Interns

Dr. Nathaniel L. Faxon, superintendent, Strong Memorial Hospital, Rochester, N. Y., spoke upon "The Problem of the Intern," indicating ways of overcoming the shortage which exists in this country. He said that eleven out of eighty-two schools surveyed were withholding the M. D. degree until after the student had completed one year of intern work. He showed that other hospitals were meeting the problem by methods of rotating service. He did not attempt to offer a solution to the problem as he said that the intern committee of the American Hospital Association as now working upon that subject would present their results at the American Hospital Association conference next week.

The remainder of the afternoon was given over to round table discussions conducted by Dr. Frank Jennings, Brooklyn, N. Y. The discussion upon the difficulties encountered in staff organization was led by Dr. Charles A. Gordon, clinical professor of obstetrics and gynecology, Long Island College Hospital, Long Island, who outlined points which make for success in that organization. He said that foremost the staff should be composed of men of activity and originality; that the chairman should be an active man, that the meetings should be conducted with dignity; cases should be reviewed in an interesting way; that regular monthly analyses should be made, announcing the best and worst record; frequent accumulative studies should be made, and that a monthly percentage card should be published.

Problem of Fee-Splitting

A discussion on hospital rules and regulations was opened by Dr. John E. Jennings, surgeon, Brooklyn Hospital, Brooklyn, N. Y., who discussed this subject from the angle of fee-splitting. Dr. Jennings showed the need for the fostering of an anti-fee-splitting morale in every community by means of education, solidarity and loyalty among the practicing surgeons. He urged that the pledge should be signed by all surgeons outside of the college.

Dr. George H. Murphy, professor of clinical surgery, Dalhousie University, Halifax, N. S., led the discussion upon the chief surgeon and the keeping of records. Dr. Murphy declared that lack of time is no excuse for the absence of accurate records, for no surgeon is too busy to devote a part of his time to the keeping of adequate records.

Dr. Edward E. Evans, St. Francis' Hospital, La Crosse, Wis., led the discussion on access to the patients' records. Dr. Evans answered the question by saying that he believed that no confidence was betrayed by the hospital by opening information, provided that the doctor desirous of the information was caring for the patient. Dr. Evans brought out that it was time to give up the idea that the patient is private property, that the hospital should look beyond the records to the doctor and the doctor look beyond to the patient.

Other subjects discussed were responsibility for case records, the record clerk, clinical laboratory and x-ray technicians, the agenda for staff conference, routine pathological examination and basis on which charges would be made, and location of x-ray and clinical laboratory with relation to service.

Symposium on Standardization

A symposium on hospital standardization featured the morning program, October 23, at which Dr. MacEachern presided in place of Dr. Albert J. Ochsner, who was unable to be present during the whole session.

The subject of case records in hospitals was divided into three discussions. The organization of an efficient case record department was presented by Dr. John Wesley Long, surgeon, Wesley Long Hospital, Greensboro, N. C., who pointed out the value of keeping adequate records, since they are the *sine qua non* of the modern hospital, and showed slides illustrating the forms used in his hos-

pital. Dr. Long believed that the department should be a major one, that every hospital should have a simple system of recording and retaining of the essentials of their cases on an up-to-date synopsis card. Dr. Carl Black, Jacksonville, Ill., talked upon the securing, supervising, and filing of records pointing out the necessity of educating the patient to cooperate in giving a full history, and the cooperation between the board and staff in the keeping of adequate permanent records.

Filing Permanent Case Records

A paper on the difficulties encountered in case records and how to overcome them was presented by Miss Zula Morris, record librarian, Butterworth Hospital, Grand Rapids, Mich. Miss Morris summarized the difficulties in the way of keeping adequate records as the following: (1) ignorance of boards of trustees and lack of financial support; (2) the securing of a capable record librarian; (3) obtaining the support of the medical staff; (4) lack of standardized nomenclature; (5) assembling statistics that mean something; (6) the quality of surgical records; (7) failure of staff to make use of the material on records; (8) difficulties of lay access to records.

Following Miss Morris' paper, Dr. Albert J. Ochsner, president of the college, made a few brief remarks at the request of Dr. MacEachern, chairman. "One of the greatest advancements of surgery," said Dr. Ochsner, "is the insistence of the college upon the keeping of adequate records in hospitals."

Place of an Adequate Laboratory

The subject of an adequate laboratory service in the modern hospital was treated by Dr. Ward Burdick, secretary, American Society of Clinical Pathologists, Denver, Colo. Dr. Burdick said that he was at variance with the college in believing that the hospital should not merely have a trained technician but should have a clinical pathologist assisted by a trained technician. He believes that the personnel of the laboratory service should consist of a clinical pathologist, a young physician assistant who intends to become a pathologist, and as many technicians as the institution can afford. He also believes that every laboratory should contain the following departments; one for the preparation of tissues and cultures, one for clinical pathology and bacteriology, one for serology, and one for chemical research.

The fundamental requirements for an efficient x-ray service in hospitals was the subject discussed by Dr. James T. Case, surgeon-radiologist, Battle Creek Sanitarium, Battle Creek, Mich. Dr. Case emphasized the importance of a fluoroscopic equipment as a growing necessity for every hospital, and that every hospital should at least have a visiting radiologist. He believes that the hospital of 150 beds or over should have a full time radiologist. Dr. Scott brought out that the object of an x-ray department is not the making of pictures, but that of enabling a more thorough examination by means of the fluoroscopic screen.

Basic Responsibility With Board

The discussion on the subject of laboratories was led by Dr. Arthur C. Scott, senior-surgeon, Scott-White Hospital, Temple, Texas. "We begin at the wrong end of standardization," said Dr. Scott. "It ought to start with the board of directors. Too many boards make the mistake of choosing men who are not qualified. One of the biggest things of the whole problem is to find a thoroughly trained individual. The superintendent should be under the head medical man and should have money back of him with which to do something." The ideal staff, Dr. Scott believes, is made up of duplicates of individual specialists. He thinks that there should be two eye and ear specialists, two roentgenologists, two gynecologists, two radiologists, and two anesthetists. In this arrangement, he pointed out, there is the advantage of one checking upon the other, and thereby greater efficiency is attained.

From 11 to 12:30 the program was given over to a demonstration of a staff conference by the staff of the Evanston Hospital, Evanston, Ill.

The afternoon program consisted of a round table conference conducted by E. S. Gilmore, superintendent, Wesley Memorial Hospital, Chicago.

Liability of Hospital in Court

A discussion on the responsibility and liability of hospitals in regard to care of the patients was led by Dr. F. W. Slobe, Chicago. Dr. Slobe said that there were two phases in conflict in the liability of hospitals; the duty of the courts in insuring best hospital care, and the holding of the hospital responsible for the medical end-results. In defining the responsibility of the hospital, he directed attention to the momentous Ohio decision which made the public charitable hospital responsible for its physicians, nurses and attendants. Dr. Slobe added that the particular circumstances of the case determined whether or not the surgeon or the hospital was responsible. In a municipal hospital where a surgeon not on the staff is admitted, the hospital is not responsible, according to Dr. Slobe.

In the discussion on doctors' orders, it was emphasized that the orders should be written in ink on the order sheet of the physician's chart, and that at night verbal orders should be directed to the head nurse, only. In discussing this subject, Dr. W. P. Morrill, Shreveport Charity Hospital, Shreveport, La., said that he found an order book in which every order was written by the nurse and signed by the doctor, the best system of carrying out the doctors' orders. He took the stand that no system where the doctor writes the orders is safe. In this connection, Dr. MacEachern spoke in favor of the bound book of 100 or more pages containing a carbon sheet to be retained by the nurse, while the original is sent to the hospital pharmacy. This system, he pointed out, has the advantage of two permanent records.

The appraising of hospital records was discussed by Dr. Hugh Wright, Buffalo, N. Y., who said that as yet most hospital records were a mass of papers. He brought out the necessity for appraising or rating records, particularly from the medico-legal point of view and from the value records have as a contribution to medical science. He urged that the person responsible for each record should sign it.

Computing Death Rates

In discussing the computing of hospital death rates, Dr. C. J. Cummings, superintendent, Tacoma General Hospital, Tacoma, Wash., emphasized the wide divergence of opinion as to what constitutes an institutional death, and pointed out these difficulties in the way of standardizing the term institutional death. (1) The certain group of deaths that hospitals should not be held responsible for, as those cases which are almost dead before the hospital has a chance to care for them; (2) borderline cases in which the responsibility is not properly placed; (3) cases which are definitely shared by a hospital.

In the discussion on recording of infections, Dr. George Stephens, superintendent, Winnipeg General Hospital, Winnipeg, Man., told how infections are recorded in his

hospital, which, according to Dr. Bacon, chairman, is a model hospital in that respect.

Dr. Stephens said that the infection record is made out by the supervising nurse, a copy sent to the superintendent of nurses and to the superintendent of the operating room. The third copy goes to the superintendent's office where it is kept in a permanent file. In the discussion reference was made to the system in use at the Philadelphia General Hospital, Philadelphia, Pa., where different colors of stars are used to represent wound, pulmonary, and other infections.

Other discussions of the afternoon were: routine for pre-operative cases, system of nomenclature, ratio of interns to patients, physiotherapy in hospitals, essentials for good case recording, and difficulties with intern service.

The afternoon program closed in time for those attending to witness the laying of the cornerstone for the John B. Murphy Memorial Building, adjoining the headquarters of the American College of Surgeons, which will house the library of the college.

GROUP NURSING AT FIFTH AVENUE HOSPITAL

By D. G. DOWLING, R.N., Director, School of Nursing, Fifth Avenue Hospital, New York City.

Group nursing has been in operation with a limited number of patients in the Fifth Avenue Hospital during the past eight months. Under this system a graduate nurse cares for two patients during the day and four patients during the night with a relief of two hours. The day nurse reports on duty at 7:30 a. m., just following breakfast. The hours off duty during the day are from 1 to 3 p. m., or 3 to 5 p. m., the nurses relieving each other. This leaves one graduate nurse to care for four patients from 1 to 5 p. m. The day nurse reports off duty at 7 p. m.

The night nurse reports on duty at 7 p. m., and is relieved either between 11 to 1 or 1 to 3 a. m. This necessitates the night nurse caring for eight patients from 11 p. m. to 3 a. m. The night nurse reports off duty at 6:30 a. m. The day nurse is allowed one-half hour off duty for lunch and dinner; and the night nurse one-half hour for midnight supper.

The day nurse, therefore, works eight and one-half hours each day, and the night nurse nine hours. The patients are on general care between 6:30 and 7:30 a. m.

The charge to the patient has been $7 for twenty-four-hour service. If forty or fifty beds were devoted to group nursing, the cost to the patient would be diminished and it would be possible to utilize the entire time of the nurse.

From the viewpoint of the doctor, this type of nursing care has been successful. The nurses, particularly the younger ones, are enthusiastic in their support of it. The patients (those not seriously ill, and the convalescent) have been decided in their praise, stating that they do not care to have a nurse constantly in the room and, also, that it is more economical. However, group nursing care is not suited to patients acutely ill, for apparent inequalities of treatment are apt to breed discontent among such patients. From the hospital's viewpoint, it has proved advantageous. The nurses, while on duty, are kept active; there is no loitering in halls or corridors and there is better cooperation between the nurse, the patient and the hospital.

LISTS NATIONAL SERVICE AGENCIES

THE MODERN HOSPITAL YEARBOOK, which will be off the press shortly, in addition to presenting a complete directory of hospital, medical and health organizations, contains a detailed outline of the services which certain national agencies, especially those connected with hospitals and allied institutions, are prepared to render freely, both to established and projected hospitals.

The following are the agencies whose services are outlined: American Conference on Hospital Service; The American Association of Hospital Social Workers; The American College of Surgeons; American Dietetic Association; American Hospital Association; American Medical Association; Council on Medical Education and Hospitals; American Nurses' Association; American Occupational Therapy Association; American Protestant Hospital Association; American Sanatorium Association; The Bureau of Chemistry; Bureau of Public Health Service; Bureau of Standards; The Canadian National Association of Trained Nurses; Catholic Hospital Association of the United States and Canada; Hospital Library and Service Bureau of the American Conference on Hospital Service; National League of Nursing Education; The National Methodist Hospitals and Homes' Association; The Board of Hospitals and Homes of the Methodist Episcopal Church; The National Tuberculosis Association; The National Organization for Public Health Nursing.

PENNSYLVANIA NURSES RE-REGISTER

An act calling for the re-registration of all nurses who have been registered in the state of Pennsylvania was passed by the last session of the state legislature. An extract from the act of the assembly follows:

On or before the first day of November of each year after the year one thousand nine hundred and twenty-three the secretary of the board shall mail to each registered nurse and licensed attendant in the state of Pennsylvania a blank application for re-registration addressing the same in accordance with the post office address given at the last previous registration. Upon the receipt of such application blank which shall contain space for the insertion of his or her name, office or post office address, date and number of his or her license and such other information as the board may deem necessary he or she shall sign same with his or her name in his or her own handwriting and fill out the address and other blanks in his or her own handwriting after which he or she shall forward such statement and application for renewal of his or her registration certificate to the secretary of the board together with the fee of one dollar ($1.00) for registered nurse and fifty cents ($.50 for licensed attendants. Upon receipt of such application and fee and having verified the accuracy of the same by comparison with the applicant's initial registration statements, the secretary of the board shall issue a certificate of registration which shall render the holder thereof a legally qualified registered nurse or licensed attendant as the case may be for the ensuing year.

The Pennsylvania State Board of Examiners wishes to announce to nurses registered under that state that blanks for re-registration may be secured from their office, 34 South Seventeenth St., Philadelphia, Pa.

The world would be better and brighter if people were taught the duty of being happy as well as the happiness of doing their duty. To be happy ourselves is the most effectual contribution to the happiness of others.—Sir John Lubboch.

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NURSING AND THE HOSPITAL

Conducted by CAROLYN E. GRAY, R.N.,
Dean, School of Nursing, College for Women,
Western Reserve University, Cleveland, Ohio

HEALTH EDUCATION AND THE NURSING SCHOOL CURRICULUM*

BY MARY MAY PICKERING, DIRECTOR, UNIVERSITY OF CALIFORNIA SCHOOL OF NURSING, SAN FRANCISCO, CAL.

NURSING education is slowly passing from the stage of training by the apprenticeship method to training by the methods used in educating for any other profession. By economic necessity, the school of nursing has in the past been obliged to provide nursing service to wards and other hospital departments. The consequent crowding of the student's time has in many instances even resulted in her exploitation as a worker at the expense of her education as a nurse. It has been with the greatest difficulty that the curriculum has been broadened to include some of the less practical and technical and therefore seemingly less vital subjects. Ten years ago, a course in hygiene probably consisted of two lectures; bacteriology was covered by one or two talks in practical nursing; pediatrics and mental hygiene were conspicuous by their absence. Bit by bit, the curriculum has been so rounded out that a nurse graduated today from the average nursing school has been drilled not only in practical nursing, in dietetics, in medical and surgical diseases, but as well in the basic sciences, in pediatrics, in communicable and mental diseases so that she is singularly well-equipped to intelligently nurse the sick.

Training in preventive medicine has been conspicuous by its absence in the curriculum of the nursing school. Schools of nursing have not yet produced evidence to show that they recognize their obligation to train health teachers as well as to develop women who are equipped with the routine knowledge of the care of the sick. If nursing schools are to fulfill their ideal of public service, they must themselves become examples of hygienic surroundings where the ideals of health are not only taught but put into practice. In the future we shall hope to see the nurse come out of the training school not merely an overworked person whose purpose is solely to follow the directions of a doctor, but herself a director of public health who will be physically and mentally equipped to promote the health movement in her general services to the community as well as in her routine nursing duties. Cooperation is needed between doctors and nurses.

Lack Training in Preventive Work

That our curriculum has still a vital and fundamental lack is clearly pointed out by Josephine Goldmark in the report of the Rockefeller Committee on Nursing Education in the United States, when she says:

"Stress upon curative medicine to the detriment or total ignoring of preventive medicine is one of the most serious handicaps in the training of the nurse. For nurses, pre-eminently those in public health work, are to be engaged primarily in the prevention of sickness; nay, more, they are to have the more difficult office of *teaching* the prevention of sickness in homes. This is their special function. It is therefore of the first importance that they should be equipped not only to recognize symptoms of disease and learn methods of cure but they should be more fundamentally equipped to recognize symptoms and conditions antecedent to disease and learn the means of combating these before disease appears. It is then surely an anomaly that their training should deal so largely with cure alone. * * * This new emphasis on something greater than pill and bottle, this stress upon the now well-established principles of hygiene and prevention is perhaps the cardinal need in the nurse's didactic instruction.

That schools of nursing have been slow to recognize their obligation to train health teachers is probably due to the same reasons that they have been slow in developing a system that will turn out thoughtful, intelligent nurses. The purpose of this paper is to outline a plan by which health education can be incorporated into the curricula of nursing schools as they are organized today. The plan would require the expenditure of little money and could be carried out by the existing teaching and medical staff,—provided its members have the necessary initiative, interest, and enthusiasm in the project to put it over.

Hygienic Surroundings—Fundamental

As a basis for the teaching of health education there must exist, first of all, in the nursing school and hospital, proper hygienic conditions. No amount of didactic instruction in disease prevention can be expected to make any impression on the minds of students if they feel that the principles taught are not being applied to their en-

*Read at the International Health Education Conference, San Francisco, Cal., July 3, 1923.

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vironment. We must see that they have right living conditions,—clean, comfortable, properly lighted and ventilated rooms, facilities for daily bathing, well balanced wholesome and attractive meals, reasonable hours of work, means of relaxation, and sufficient recreation.

We must provide a yearly health examination for the individual student as well as the entrance examination now almost universally practiced. We should require monthly weighing, with the opportunity for comparison of the actual weight with the normal; we must provide the mid-morning lunch; immunize against infectious diseases, correct physical defects. If the student has carious teeth, they should be treated; if infected tonsils, they should be removed; if poor posture, she should be taught its correction; if she is underweight, she should be nourished; if overweight, dieted.

Sell Positive Health Ideal

In addition to these things, she should have sympathetic and stimulating health advice and supervision throughout her course. At her first physical examination, she should have "sold" to her the positive health ideal, and have implanted in her mind the thought that one of the chief services a nurse can render is to teach health to individuals, and that she can most effectively teach health to her patients by being radiantly healthy herself. At subsequent conferences, interest can be sustained by observing progress made through her own efforts as well as by outside guidance. Her ability to give service by personifying health is one avenue of appeal; her inherent desire to be beautiful or at least attractive, forms another. But more important than either of these is an understanding attitude on the part of her physician-advisor.

The provision of healthy environment and the opportunity to realize her own health ideal is the first step in preparing the nursing student to become a teacher of health. The second step is to give her methods which she can practice with her patients.

Course in Health Education Needed

Most nursing schools give in the senior year a course of sixteen hours in so-called occupational therapy, in which the student learns to weave baskets, mould beads and to do other craft work which in my experience I have rarely, almost never, seen applied to her patients' needs. Why not substitute the same number of hours in health education methods and transfer the course to the second half of the first year?

This would seem the logical place for such a course, for by the end of her preparatory period, or preliminary term, the student has developed her nursing technic to the point where she is beginning to follow it subconsciously; her mind is reaching out for something new. Because she has done comparatively little actual work with the patients in the hospital wards, her attitude of mind toward that work has not yet crystallized. What an opportunity for the direction of her mind along health lines,—for the teaching of methods by which she may interest her patient in positive health while she is performing for him the routine nursing procedures. This course following close upon her first physical examination and subsequent health instruction by her physician-advisor, would seem the psychological place to develop in the student a vast enthusiasm for health,—a natural and intelligent interest not only in caring for the sick patient but in trying to influence him in his environment so that he may keep well. Trite as it may sound, she has entered the nursing school because of her desire to be of service in the world. While her mind is still plastic, while she is eagerly trying out her new found powers, why not capitalize that desire for social service and teach her to use it in her everyday routine work,—along with the making of beds, the serving of trays, the giving of medicines?

It is unnecessary to describe the well-known methods now being used in teaching health. It has been demonstrated that the majority of nursing students may be interested in learning and applying them, and for the less imaginative, interest may be sustained by a judicious distribution of craft work throughout the course with practical application to health education. Beauty examinations, short snappy debates on health, and the working out of practical suggestions by the students themselves serve to stimulate the imagination and develop initiative.

Knowledge of Background Essential

When she begins to apply to her patient what she has learned in the class room, the student finds that the work with children is usually play, but that just as the health ideal has been made vital to her by the physician who is her health adviser, so must she be able to get health teaching across to the adult patient by studying him as an individual. In doing this, she finds she must know something of his background, his environment and social history. She discovers, too, one of the greatest compensations of the nurse, the realization that because she is able to relieve his suffering and help to heal his body that the patient looks upon her as a friend and helper, and that because of this feeling of gratitude and confidence, he is willing to be influenced by her. She may find that while many adults can not be reached by definite and direct instruction, they will quickly respond in helping with health projects for children—as in making posters, the health house, health land, the health theatre, and so forth—and probably absorb some of the rules of health. Here, too, she sees the psychological importance of her ability to radiate health as a practical example to the patient of the result of playing the game. Her eyes are bright, her skin is fresh, her carriage erect, her disposition happy, her whole body radiating wholesome vigor.

The Nurse as a Health Director

That the nursing student should direct the health work now being carried on by lay workers in the hospital wards and clinics would be a natural development; and her knowledge of the health movement, her interest in the health program, and her instinctive desire to give the patient something of herself, something more than routine nursing care, will find many outlets in her daily work thereby vitalizing that work and establishing within herself the habit of thinking in terms of health.

In this course while she learns the history and progress of the health educational movement, most of the emphasis is placed on actual methods. Our third step is to carry the teaching into the second year where it can be broadened and made to include medico-social aspects of health work, or sickness and health in relation to the community. Again quoting Miss Goldmark, "the school of nursing should give to every student in class room and ward that minimum of social interpretation and instruction in the social aspects and prevention of sickness which is indispensable in the modern treatment of disease." These classes could take the place of some of the unrelated lectures now being given in most schools in the senior

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year or could be given in addition to those lectures and could be made most interesting and stimulating. They could consist of original study of individual patients in the hospital wards and the out-patient department with conferences on the actual and possible methods of handling them from the point of view of efficiency to the patient, to the community and to the state, lectures by people doing various phases of social and health work with emphasis on the nurses relation to this work, visits to organizations and agencies, outside reading and reports on the great pieces of public health work being done through the world—the anti-tuberculosis program of Framingham, Massachusetts, the organization and development of the health program of Mansfield, Ohio, the health center of Alameda County, California, the work being done with heliotherapy and nutrition in Vienna, the work for undernourished children in Belgium.

An important consideration in giving both these courses is not to lose sight of the individual patient in the study of methods and organization. Practical application of means and methods should be made throughout with the aim to stimulate not only the nurse who plans to do public health work but to open the eyes of the private duty nurse to a vision of her opportunity and obligations in the teaching of health.

Need Educational Basis

We confidently look forward to the day when schools of nursing will be established on an educational basis—when our first consideration will be to provide in the approved pedagogic manner all the fundamentals necessary not only to care for the sick but to teach health and the prevention of disease. While we recognize that with the time available in most nursing schools today, it would seem extremely difficult to crowd into an already overcrowded curriculum a course of thirty hours in preventive medicine such as is recommended by Miss Goldmark—is it not easily possible to have health education and disease prevention stressed in every course given in the curriculum—in hygiene, in nutrition, in dietetics, in bacteriology, in physiology, in pediatrics, in obstetrics, in every branch of medicine and surgery, in communicable diseases and in mental diseases?

Will not this emphasis on the necessity for teaching prevention challenge the attention and interest and efforts of the student, develop her imagination and initiative and animate and vitalize all of her work? If she is interested to see that children eat their meals, will she allow the dessert to be served simultaneously with the soup and consequently eaten before the soup? If she is to teach the undernourished patient the vital importance of assimilating his high calorie diet, will she not be interested to see that the meal she serves that patient is well-balanced, well-cooked, hot and appetizingly served? If she is telling a nephritic patient the importance of skin elimination is she not likely to emphasize that instruction by giving that patient the best bed bath she knows how to give? If she must teach health by radiating health and happiness, will she feel that she dare go about any of her work in a half-hearted, listless manner?

Importance of Demonstration Work

I have said that we must provide a hygienic environment as a basis for training the nurse in the teaching of health. Our fifth step in that training is to demonstrate to her the function of the hospital as the health center of the community, as indicated by Dr. Willard Rappleye, "we must show her the hospital as a cooperative organization of workers and leaders devoted to the ideals of their respective professions, not merely as an institution for the salvage of human wreckage but *a co-ordinator of activities, professional, economic and social, in their application to the problems of health.*"

What she observes about her will influence her more than what she hears in the class room. In the out-patient department, she should see preventive work being done in the tuberculosis clinic, in the prenatal clinic, in the well-baby clinic; in the dispensary and in the wards, she should find the patient diagnosed socially as well as medically. She should observe the hospital reaching into the homes of the patients to educate and make social adjustment. She should see plans evolved to give adequate professional care to that great group—the people of moderate means not eligible for free service but not rich enough to pay for private medical and nursing care. She should, in short, learn to look upon sickness as not merely a hospital case but as a family and community problem in whose solution she as a professional worker has a definite part.

Observation to Reinforce Instruction

To summarize, the hospital and nursing school should provide in the curriculum didactic instruction in the prevention of disease, in health education methods, a study of the social aspects of disease and the world's health program. This instruction, however, must be reinforced and emphazied by the student's daily observation of the way in which the nursing school gives her the opportunity to attain her health ideal and by the way in which the hospital itself handles the sickness and health problems of the community.

The first result of developing health education in the nursing school will be to make the individual nurse healthier, happier, and more efficient. Even under present conditions, faulty as our organization is, we can, if we will, give her the opportunity to realize her health heritage. But more than that, we can, if we will, develop in her a habit of thought, an attitude of mind, that will impel her, even in private duty, to seek out opportunities to teach health and the prevention of disease. It may seem difficult, almost impossible to plan for, but if we are to prepare our nurses to fulfil their dual function of caring for the sick and of preventing disease, we must find a way of incorporating this instruction in our curriculum.

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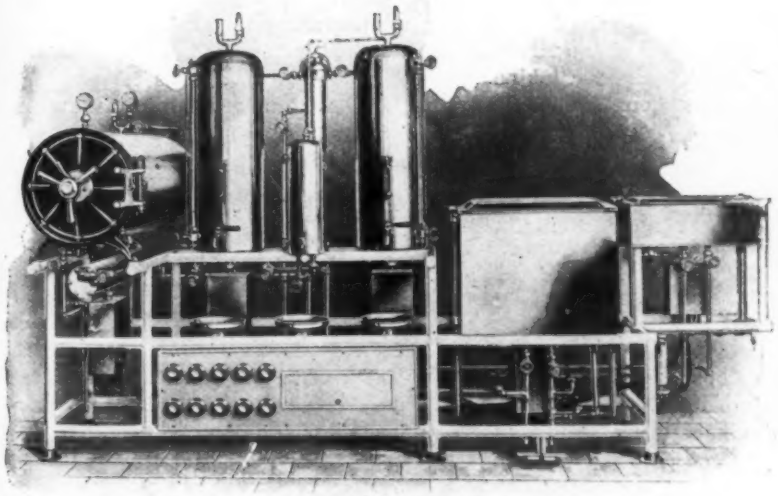

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Conducted by LULU G. GRAVES,
Supervising Dietitian, Mt. Sinai Hospital, New York.

RELATION OF A DIETETIC DEPARTMENT TO THE MEDICAL SERVICE OF A HOSPITAL

BY C. D. CHRISTIE, M.D. WESTERN RESERVE UNIVERSITY AND LAKESIDE HOSPITAL, CLEVELAND, OHIO.

IT WOULD seem that anything which affects mankind so intimately as his food supply would have been the first thing to be thoroughly understood by our ancestors, but apparently that which was most available was the food chosen. Hippocrates noted that an adult might partake of a lot of food without gaining in weight, and he believed it to be due to the fact that the individual constantly loses heat through insensible perspiration. This observation probably represented one of the earliest nutritional studies. Little progress was made from that time up to the seventeenth century, when Sanctorius performed his memorable experiments upon himself. After Sanctorius we find rapid development in the science of nutrition, and with this development are linked the names of the world's foremost scientists, such as John Mayow, Priestley, Lavoisier, Laplace, Liebig, Voit, Pettenkofer, Rubner, and finally the American group who have contributed so much to the subject, namely: Lusk, Benedict, Mendel, and Funk.

In presenting this paper I should like to discuss in a general way the subject of nutrition; to show how vital its fundamental principles are in the treatment and management of sick people; to discuss its intimate bearing upon society both from an economic and a medical point of view; and finally to impress upon dietitians that the scope of their work is in a certain sense unlimited, that the surface of the subject of nutrition has scarcely been scratched, and that to keep pace with this rapidly developing science higher and higher standards must be demanded for those who would take up the profession.

Progress in Science of Nutrition

Nutrition has advanced for the most part hand in hand with chemistry and physiology. These two sciences have given us the clew to a fuller understanding of the constituents of foodstuffs and the changes during digestion, and finally some slight appreciation of the wondrous secrets of the metabolic processes. Our knowledge of the component parts of foodstuffs has advanced far, and most of our conceptions of the actions of body secretions upon foodstuffs during digestion are probably in the main correct; but from the time that digestion is complete and the end products of digestion—namely: amino acids, glucose, fatty acids, salt, water and vitamines—are absorbed into the blood stream, our information concerning the subsequent disposal of them to maintain the balance which we term metabolism is exceedingly sketchy.

What takes place in the body when these component parts of the food we eat meet in the blood stream with the oxygen which we breathe? How does the heart get its proper supply, and how does the brain get its share? What is the mechanism which determines what proportion of amino acids taken from those floating in the blood shall go to supply the needs of the brain? There are many kinds of amino acid formed in our intestines after each meal, though some foods are deficient in certain kinds; and as far as we know the body needs all of them, each being a different and distinct entity. Then by what rule do we supply these particular substances to our body, and how do we know we are supplying the food which contains the right kind. One might carry this series of questions on indefinitely, showing how totally lacking we are in certain fundamental information along nutritional lines.

For several years, development in nutritional studies as related to treatment and prevention of disease has advanced very fast. This has been particularly true of the so-called deficiency diseases such as beriberi, scurvy, pellagra, etc. These advances have been made by means of relatively simple experiments. From now on the results in these lines will come more slowly, as experimentation will be more difficult. These deficiency diseases are due to the absence of certain vitamines from the foodstuff, and feeding experiments with small animals were sufficient to detect them. Pathological conditions in the human body due to deficiency or superabundance of certain amino acids or particular salts are bound to be slower in detection. The physico-chemical pathologist must first describe the lesion in the cells; the medical man must recognize these lesions on patients; and the physical chemist must tell us what is wrong. It is conceded by scientific men that, by advancing our knowledge along these fundamental nutritional lines, there is great hope for the building up of a physically more perfect race with bodies more capable of resisting disease.

Experiment in Diets of Animals

One might cite the experiments of Mr. Babcock and others at the Wisconsin experiment station as evidence pointing in this direction. In a series of pregnant cows, some were fed wholly upon a diet of corn, others on wheat, others on oats; and still others on a mixed diet of wheat,

*Read before Ohio Dietetic Association, May 20, 1923.

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oats, and corn. They were all handled in exactly the same way and were not allowed any other food. It is a very significant thing that those which lived entirely on corn carried their young until term and gave birth to calves which were large, hardy and strong. In the wheat-fed ones, the calves were born several weeks too soon and were in most instances either born dead or died a few days afterward, and they weighed about half as much as the calves of the corn-fed mothers. The cows themselves kept about equal in weight but the corn-fed ones were sleek and strong, while the wheat-fed ones were gaunt and rough-haired. The oat-fed ones stood between. These are significant facts. What is the explanation?

We have chosen the food upon which we live by the rankest kind of empiricism. Our ancestors lived in a narrow sphere; they chose the food which was closest at hand, that which grew on a neighboring vine or bush. As time went on they planted and cultivated that which caused the least exertion and gave the greatest yield. There was no particular thought as to what was good for them, unless perhaps something caused sudden acute sickness. Slow disastrous effects were overlooked, as they are doubtless in many instances overlooked by us today. Our eating is, then, largely determined by the habits of our ancestors.

Dietary Problem of the Obese

This hereditary lack of dietary wisdom is seen in the obese, and we have much evidence that obesity is a serious condition. It is a common experience that an obese person does not stand a severe illness well. Life insurance companies look with far more suspicion on the man who is twenty-five per cent overweight than they do on the man who happens to be the same amount underweight, providing that both are normal in other respects. It is common knowledge that nearly all diabetics are recruited from the fat. People past forty years of age and overweight supply us with the great majority of instances of high blood pressure, and therefore many premature deaths.

However, it seems rational to suppose that the majority of instances of obesity are preventable, but the eradication of the condition after it is well developed is not so easy. The type of civilization which we are now fostering predisposes to obesity. The two main factors in its production are sedentary habits, which are encouraged by electrical appliances and the automobiles; and the excessive consumption of carbohydrate food as bread and sweets. During the last several years the per capita sugar consumption in America has gone up by leaps and bounds, and so has the waist line. The chief statistician of a large life insurance company has recently made the observation that the frequency of constitutional diseases in general increases as age advances, but that diabetes is an exception to the rule in that its incidence increases with age only with the fat, while in the thin it remains constant throughout life.

There is gradually accumulating evidence to show that extensive nutritional studies are necessary to explain certain pathological conditions among people in various parts of the world. I am firmly convinced that something in our dietary is wrong. Among the Japanese, diabetes is practically unknown, and so is obesity. May this fact not be due to some perfectly simple dietary fault which we have lugged along with us generation after generation? After all, our eating and craving for certain foods are habits. The sweets of which we think so highly would be spat out by an Eskimo if he happened to get some of them into his mouth. The Eskimo is able to eat a meal almost solely of protein and fat and then lie down in the snow and sleep for hours without dire consequences. This fact is usually explained as owing to a specific dynamic action of the protein and fat in elevating metabolism and, therefore, heat production. But may not the superabundance of protein and fat in his food contribute to a human mechanism which is more sturdy and, therefore, resistant to bacterial invasion?

Dietary Relation to Decay of Teeth

There is some evidence that decaying of teeth may be explained on a dietary basis. The mere fact that teeth decay may not of itself be of great importance, but it may be associated with a deficiency which is clearly of importance, if diseased conditions are to be resisted. One can also cite the prevalence of goitres in certain districts as probably owing to dietary deficiency. These are all important questions. They must be answered, and the world looks to those engaged in nutritional medicine to give the answer.

Scientific men who are devoting their efforts to this line of study need dietitians. Well trained dietitians are an absolute essential to the continuation of this kind of work. I venture the prophecy here that the next ten years will see more rapid strides in this field of medicine than in any other. The bacteriologist is not likely to give us anything very startling as far as the explanation of certain diseases is concerned. The histological pathologist and the surgeon are also essentially in the position of stalemate so far as any light shed from their point of view. The answer will come to many of these vital questions through the development and extension of nutritional studies. Lusk said in 1917, "In another decade the development of scientific knowledge will probably permit the formulation of the subject from the standpoint of physical chemistry. It cannot now be so treated." I can only venture the guess that it will not be so long.

You, as dietitians, must appreciate the trend that this field of medicine is taking. As was said earlier in this paper, the surface of the subject has scarcely been scratched. There is a future for your services and you must be constantly on the alert to make yourself more efficient and to see that those who are taking up the work are fundamentally well trained to carry the load.

Up to this point I have tried to point out the direction that nutritional studies are taking. So far I have said very little about those facts of nutrition which are well understood. Already the work which a well trained and well organized dietetic department is able to do in a hospital or a community is indispensable. It is not the physician's work any more than is the nursing care of the patient the duty of the physician. However, without well trained physicians a nurse's services would be extremely limited. I hold that the sense is true of the dietitian. Her services are well nigh useless unless they are intimately bound up with sensible medical direction. It is my impression that an efficient medical department in any hospital which is keeping abreast with the rapid developments in nutritional medicine cannot operate to maximum efficiency without an equally well balanced dietetic department. Unfortunately, most of the diseased conditions where diet is an important factor are chronic conditions extending over months or years. In most cases treatment demands a complete reversal of the patient's mode of eating. He must be instructed along new lines.

Proper instruction in any new dietary regime entails not only explaining the fundamental principles by which the

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patient is to be guided, but set consultations and demonstrations. The day is past when a physician, who expects results, can tell a patient to go home and not eat thus and so, or give him a printed slip and say this is what he is to eat. That way of doing it, is not satisfactory because of several reasons. The first is that the patient eats everything on the slip the first week, tires on the second, and then eats what he likes. Those who understand the fundamental principles on which the diet is based can generally prepare an unlimited variety of foodstuff which will meet all the requirements of the stingy little slip of paper, and thus keep the patient satisfied and more nearly insure results. The physician who takes his patient through a month of gastric ulcer routine and stops there, we now know is derelict in his management. Such patients must be treated for six months or a year on dietary measures. We cannot hospitalize them for that long, and mostly we cannot keep them idle for more than a month. Is the average well trained physician going to take the time to instruct the patient in detail each few weeks as to what he can carry in his lunch basket which will meet the gastric ulcer requirements, and at the same time keep the patient contented and happy? Generally he will not.

We have well demonstrated in the out-patient department of the Lakeside Hospital that a large percentage of the chronic stomach complainers—I mean those who have little pathology but a high morbidity rate—are suffering from undernutrition with an accompanying gastroptosis. Many have brought it on themselves by unnecessary restriction of their food for one reason, or another, many from inadequate convalescence after an illness. It is this class of patients from which the surgeon recruits the great majority of his unnecessary surgical operations. We see patients who have had one, two, three and sometimes four abdominal operations and the same discomfort afterward. We have taken them and have given our dietetic department carte blanche orders to build them up. In many instances the results have been perfectly brilliant.

Ignorance of Relative Food Values

No physician is going to take the time and not one in ten has the training to sit down and thrash this sort of thing out with the patient.

It is surprising how ignorant many well educated people are in matters of food value. Many I am sure would tell you that a pound of lettuce is as efficient as a pound of navy beans. Such instances of ignorance make the question an important one from an economic point of view, and the information needed can be disseminated in a community by a well organized dietetic department. What is true of gastric ulcer patients and those with gastroptosis holds notably true for a variety of other conditions. I need only mention diabetes, nephritis, obesity, etc. I personally have felt more and more strongly that the dietetic staff of a hospital should be given better facilities for the conduct of their work. The information which they disseminate is vital to the normal as well as the sick. We have constantly tried to give the dietitians more duties and opportunities in our hospital and have, in most instances, felt that their work should be continued and extended.

To show what a person trained in dietary procedures may accomplish, I will cite an example. Recently we had a very intelligent diabetic patient in our hospital from a city of about 40,000 in a neighboring state. This man was very carefully taught the details of calculating his diet. When he went back to his home town, there was a diabetic patient in their hospital who had a gangrenous toe and who would not get sugar-free on the rather crude dietary measures employed by their doctors. They had no well trained dietitians, and the doctors finally called upon this man to go to the hospital and see if he could feed this patient so that he would get sugar-free. By employing the starvation routine, he got the patient sugar-free and doubtless contributed in no small measure to saving his life.

Need For Skilled Dietitians

There is something radically wrong with physicians or a hospital that will allow that sort of condition to exist. After all, however, the responsibilities fall back on the physician's shoulders. If he be progressive and alert to the developments along these lines, he can advise his hospital to provide adequate facilities for a diabetic department, and when a few instances such as the foregoing are pointed out it will not take such a department long to materialize. A dietetic organization in a hospital need not interfere in any instance with the prerogatives of physicians, nurses, or social workers. In fact a capably organized dietetic department can be of as distinct service to the nurses and social workers as it is to the physician. It must, however, be given adequate facilities for consultations and demonstrations with patients.

In closing, let me briefly recapitulate the points which I have tried to bring out in this paper. The science of nutrition has progressed far during the past hundred years, but nutritional medicine has been built up in the main during the past ten years. There are many diseased conditions now which can be satisfactorily treated only by dietary measures, and this number will gradually increase as nutritional medicine develops. This development may be slow, however, from this point on, as it entails the application of a new and fundamental science, namely: physical chemistry.

Diet as a Disease Preventive

Nutritional medicine has developed sufficiently far to prove that it is possible to prevent certain diseased conditions which now yearly exact a great toll of human lives. I mean, particularly, obesity in its relation to diabetes and high blood pressure. Hospitals and physicians must appreciate these developments in nutritional medicine, and they must realize that it is possible to take advantage of them only through a well trained dietetic department. Dietitians must appreciate the gradually increasing scope of their work and must constantly attempt to improve the educational standards of those who would take up the work. Furthermore, they must appreciate their two-fold duty; first, to disseminate freely to the community knowledge which will lessen economic burdens because food will be of greater caloric value and therefore less will be required for the nutrition of a family, and because it will prevent certain diseases; and secondly, to form a link in the chain which is essential in the treatment of certain diseased conditions.

Finally, in conclusion, let me say that if by this paper I have succeeded in disclosing to you the likelihood that your work will have increased in usefulness in the next ten years far more than it has in the past ten, I shall feel amply satisfied. For I believe if you appreciate that, you will go back to your work with renewed interest and will constantly try to become more capable of fulfilling your obligations to the community.

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HOSPITAL EQUIPMENT AND OPERATION

With Special Reference to Laundry, Kitchen and Housekeeping Problems

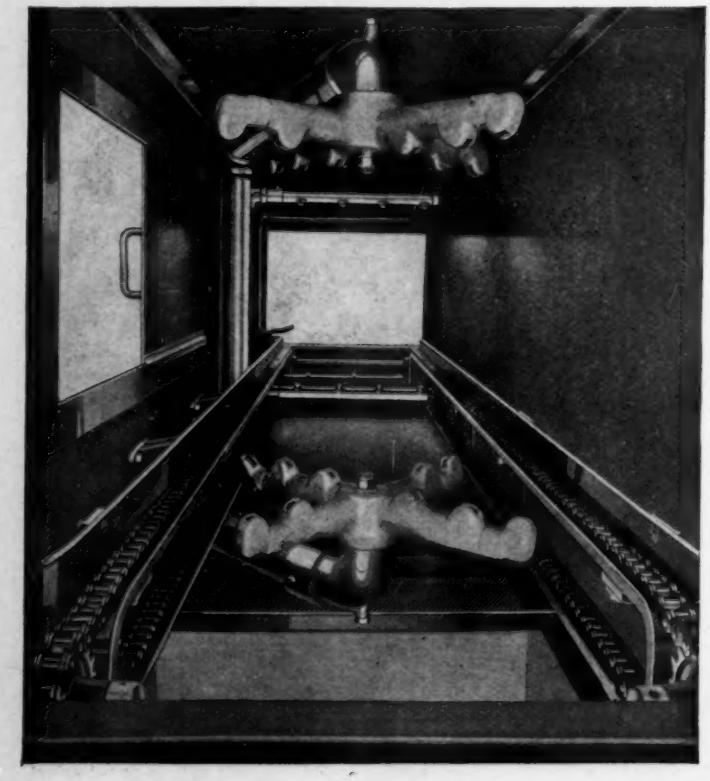
Conducted by FRANK E. CHAPMAN, Director
Mt. Sinai Hospital, Cleveland, Ohio

A NEW HIGH SPEED AUTOMATIC DISHWASHER

A new high-speed dishwasher suitable for medium and large size institutions has just been perfected. It is interesting to learn of the improvements in design and the advantages to be secured by the use of this machine. The outstanding improvement of this dishwasher is its capacity for washing 15,000 dishes an hour. It is a chain conveyor type, of simple yet rugged design.

The illustration of the interior of the dishwasher very clearly shows the method of operation. The double revolving wash has already been used in smaller machines. The dishes are stacked in racks, thirty-five dishes to a rack, and these racks pass through the machine at the rate of 8½ racks a minute or 15,000 dishes an hour.

Yet, in spite of this high speed, the machine is only nine feet long and less than three feet wide. All operating parts of the machine are easily reached from the front of the machine. It may therefore be placed against the wall resulting in the saving of considerable floor space. The dishwasher weighs 1,800 pounds in monel metal or copper and 2,250 pounds in galvanized iron material.



The dish racks are furnished with the machine. They are twenty by twenty-four inches in size, with a capacity of thirty-five dishes each. The dishes are placed in the racks at the soiled dish table. Each piece of tableware passing through the machine is washed and rewashed about twenty times—both from above and below—by heavy streams of hot soapy water under pressure. The dishes pass through two rinsings. The final rinse is automatically turned on and off by the racks in passing so as to insure a minimum water consumption.

The wash water tank has a capacity of eighty gallons of water and the rinse water tank holds fifteen gallons. In operation, the two four-way wash arms with ten nozzles each, pour hot soapy water over the dishes at the rate of 475 gallons per minute. The machine is equipped with a five horsepower electric motor—and a double chamber centrifugal pump—with ring oiled, cut-board bearings. This motor and pump is located under one end of the machine—out of the way—as is also the one-half horsepower motor for the conveyor.

This dishwasher is manufactured for operation of right to left. Special machines with left to right operation can be furnished at no extra charge.

A small detail, yet an important one, is the wire strainer pan, illustrated in the picture. This pan catches the food particles and it is taken out of the machine through a water-tight door in the front of the machine.

Every effort has been bent towards making this dishwasher so simple, so rugged and so fool-proof, that it will give satisfactory service in the hands of even the most careless kitchen employee.

CARE OF THERMOMETERS

By MARY MAY PICKERING, Director, University of California Training School for Nurses, San Francisco, Cal.

Three thermometer holders which seem to answer the need of any type of hospital have recently been placed on the market.

Figure 1 shows the thermometers for the individual room, or cubicle. The white enameled holder containing a test tube is fastened to the wall, door, or window frame by means of screws. The test tube has a small bit of cotton in the bottom and is filled with disinfectant to one-eighth inch of the top. The thermometer placed in the tube should be covered by the solution within one quarter inch of the end. Each morning the tube may be removed from the holder, washed, and the solution renewed. If the room is vacated the tube is left dry and the thermometer placed in the supply closet.

Figure 2 pictures a thermometer rack which may be used either for private rooms or a ward. It is made of cast aluminum, highly polished, and is light, com-

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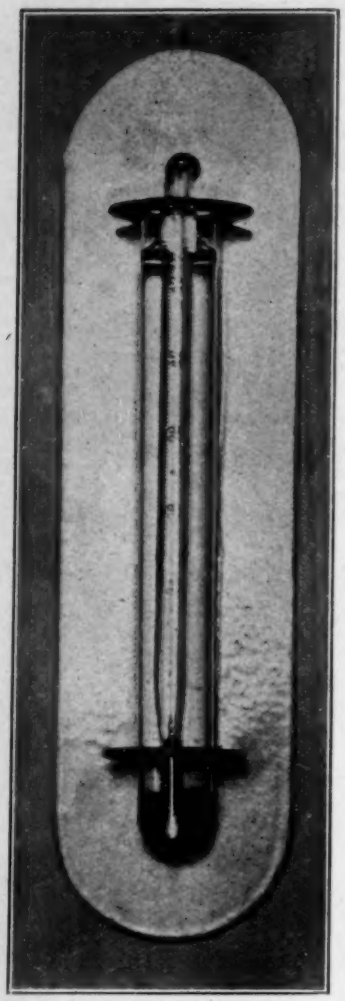


Fig. 1. White enameled holder for thermometer.

pact, and exceedingly attractive. It holds sixteen test tubes for mouth thermometers, two for rectal, small glass receptacle for lubricant, and three larger glass receptacles, one for clean cotton, one for used cotton, and the third containing water. Beside each test tube, the number of the room is marked on the aluminum surface with a china marking pencil. It could also be marked by means of the small gummed figures that are so commonly used.

Of these two holders Figure 1 would seem more desirable for private rooms as there can be no question in the patient's mind as to promiscuous use of his thermometer when it remains in his room. It is small, neat and trim. If desired, it could be placed out of sight on the inside of the closet door or in the bathroom. In both types of cases care must be taken to have in the bottom of the test tubes just enough cotton to act as a cushion so that the thermometer may be nearly immersed and therefore efficiently disinfected.

Horizontal immersion of thermometers in the disinfectant is much safer from the point of view of sterilization than the vertical method described above. For this reason a third holder was designed (after the Force-Kerr thermometer tray). This holder is made of highly polished cast aluminum and consists of three compartments, each being five inches long, two inches wide, and one and one-fourth inches deep. Figure 3 shows the holder with thermometers ready for use. A small tray

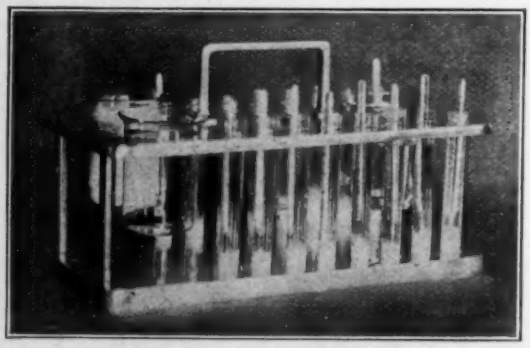


Fig. 2. Rack made of cast aluminum holding eighteen thermometers and four glass receptacles.

contains the following articles: (a) small thermometer tray, in the bottom of each compartment of which is placed a thin gauze pad, six thermometers, (three in compartment 1; three in compartment 2), (b) three small glass jars, one for clean cotton, one for used cotton and the third for water. Each compartment contains alcohol seventy per cent to the depth of one-half inch.

The nurse, in removing the thermometers from the alcohol tips the tray to bare the upper end of the thermometer, takes out the three thermometers, shakes each one down and places in patient's mouth. The thermometer *is not wiped* before using. As it is returned, it is rinsed in water, wiped, and placed in compartment 3.

Fig. 3. Holder containing thermometers ready for use.

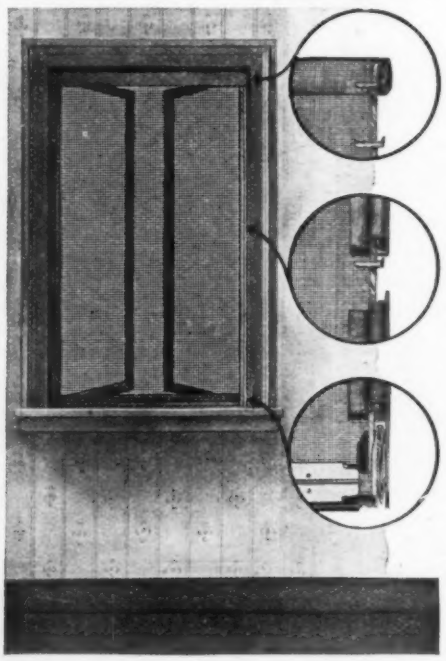
Thermometers from compartment 2 are used and returned to compartment 1 and so on until the temperatures are taken. When all are finished, the alcohol is poured off into the waste alcohol bottle, the holder dried, and the tray set up for future use.

The holder as made has three separate compartments so that thermometers returned to one compartment do not contaminate the solution in another. As the temperature, pulse, and respiration of three patients cannot be taken and recorded in less than six to eight minutes, each set of thermometers has sufficient time for disinfection after use.

NEW SELF-CONTAINED SCREEN

A new self-contained screen has been devised to meet the problem of damage incident to removal and replacement of screens, and to eliminate the necessity for furnishing of storage facilities for them.

This new screen is of interest to hospitals and other



institutions because of its advantages over the ordinary window screens. The roll up screen may be left on the window all year as it will not rust or corrode. The screen lies flat on the window so that there are no gaps and it does not pull out on the sides.

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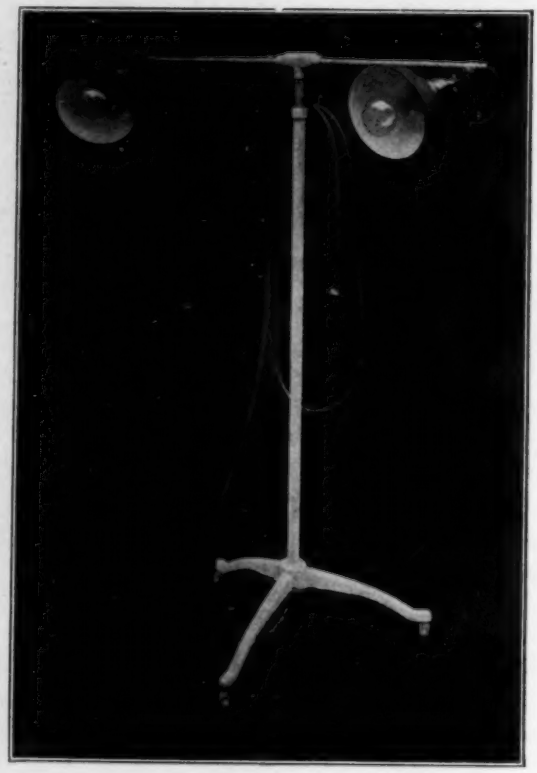
It can be removed from the window merely by raising it the same as the window is raised. Thus it has this added advantage in facilitating window washing. When not in use it rolls up and is self-contained. This new screen eliminates a great deal of handling and saves time spent in caring for the ordinary screens.

PORTABLE OPERATING AND DELIVERY ROOM LIGHT

By L. A. SEXTON, M.D., Supt., Hartford Hospital, Hartford, Conn.

This portable operating room light is of as simple construction as can be made, and was designed by the writer for use in gynecological and obstetrical work, particularly in perineal repairs.

The light is intended to stand directly behind the operator with one light throwing its rays over each of his shoulders, converging at the field of operation and parallel to the patient.



New portable operating room light.

It has four adjustments controlled by thumbscrews which make it possible to converge the rays at any desired height or angle.

IMPROVED INHALATION KETTLE

By T. R. PONTON, M.D., Vancouver, British Columbia.

During my period of service in the Vancouver General Hospital and when visiting other hospitals I have been impressed by the utter inadequacy of the means used for giving steam medication to patients and as a result have attempted to devise an inhalation kettle which would be free from danger of fire and would deliver a good volume of steam to the patient in a tent or in the open ward.

This outfit consists of a wire cage, a kettle and a tube. It has been in use in the Vancouver General Hospital for nearly a year and is entirely satisfactory. It is not patented and may be made by local mechanics.

The cage is cylindrical, fourteen inches in diameter and fourteen inches high, diamond mesh construction, the wires being one and one-half inches apart. The frame of the cage is made of number nine and the mesh number fourteen galvanized wire. One inch from the bottom of the cylinder a wire mesh floor is attached—of the same construction as the main wall and having attached in its center a triangular plate of galvanized iron, of a size to hold an electric plate with the edges turned up one-fourth of an inch. In one side of the cage is cut an opening eight inches wide by eleven inches in height which is closed by a door hinged at the top.

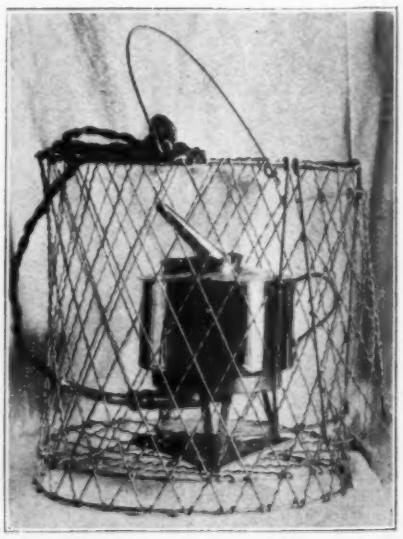
New improved inhalation kettle.

The kettle is of copper, nickel plated, seamed wherever possible. It is seven inches in diameter with walls four inches high and has a slightly domed top. At the center of the dome is an opening one and one-fourth inches in diameter into which screws a spout coming off at an angle of about forty degrees. This spout is tapered to an outlet one-fourth inch in diameter. At one side is an opening one inch in diameter into which is seamed a tube which goes to within one-fourth inch of the bottom of the kettle. Surrounding both these openings is a flange which directs any drip from condensation into the side opening.

The tube is three feet long, one inch in diameter, covered with asbestos.

The following instructions for use are issued:—1. Place the electric plate on the triangular iron plate in the bottom of the cage in such a position that the switch is opposite the door, the electric cord being brought through the mesh in any convenient place.

2. Fill the kettle about one-third full (not less than sixteen ounces and not more than forty-eight ounces) through either the side opening or the screw cap. Cork is not to be used in the side opening. When steam is seen coming from the side opening it is a warning that the kettle is nearly empty.



Steam kettle enclosed in wire cage which is in use at Vancouver General Hospital.

3. Medication will be poured into the kettle by unscrewing the cap carrying the spout, and not through the side opening.

4. Heat the water on the gas stove before placing it on the electric plate.

5. Place kettle in cage, on plate, with handle toward the door and spout pointing toward back of cage.

6. Sit the cage on the floor in any convenient position.

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7. Insert long tube through the meshes of cage so that it will go over the spout of the kettle and to the bed of the patient.

8. The spout is not to go more than two inches inside the bed or tent.

9. The spout and steam will be hot. Adult and responsible patients are to be warned not to get too close to either. Children and irresponsible patients are to be sufficiently restrained to prevent coming in contact with the pipe or the steam.

NEW DOUBLE-DECK ELECTRIC BROILER

One of the latest electrical devices that have come into use is the new double-deck electric broiler. It consists of two broilers in one—each operated and heated separately. Thus, the user obtains twice the ordinary broiler capacity, with no increase in the space occupied, and a comparatively small increase in the original cost.

This broiler is of the heaviest duty type, and is especially designed for hotel and hospital kitchens of the

best class. The heating units are tubular electric strands, which give tremendous heat, and have unusually long life.

Each deck of the broiler is arranged with two heating units, each fitting half the broiling area. This permits broiling on one side of gridiron only, thereby conserving current. All heating units are controlled by three heat switches giving high, medium and low heat. Two sizes are made, thirty and thirty-six inches, having a maximum power requirement of fifteen and twenty kilowatts, respectively.

The entire broiler body is made of heavy polished black Wellsville steel, with polished steel trim. The hardware is of heavy steel or brass, finely polished.

NEW RUBBER SHEET AND HOLDERS

The question of proper rubber sheets, their maintenance and preservation, has always been of great importance to the hospital. In an attempt to manufacture a rubber sheet that would be more durable, the tendency has been from time to time to develop a heavier sheet, with the result that rubber sheets on patients' beds have become increasingly uncomfortable.

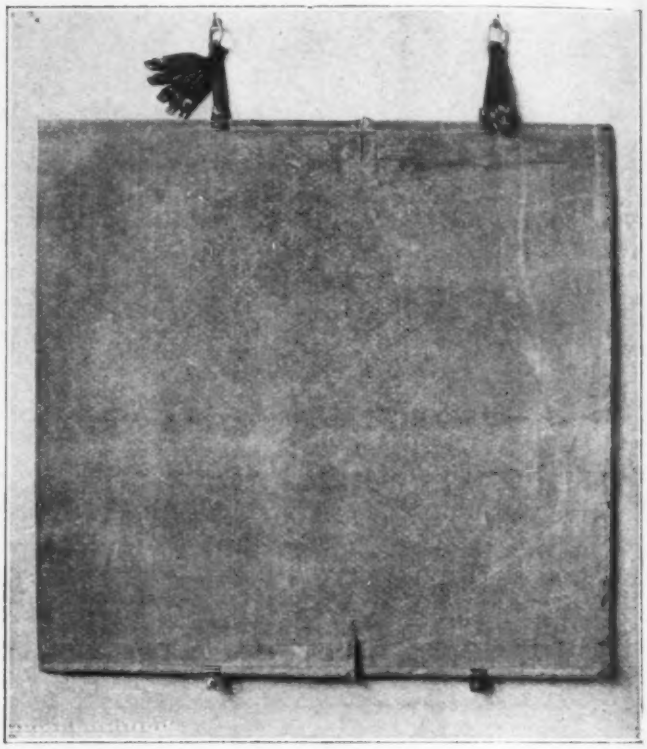
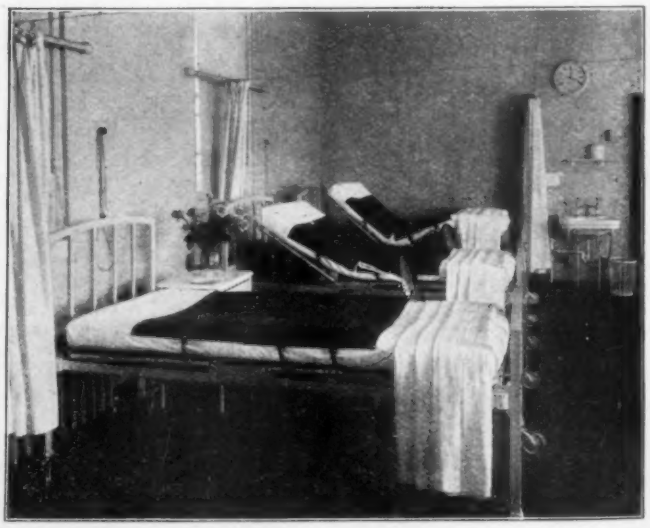


Illustration shows rubber sheet fastened to the wall.

A thinner type of sheet that will have all the durability of the heavier sheet and still be more comfortable for the patient has been developed. With the lighter sheet has come the necessity of devising ways and means of keeping the sheet smooth, and the necessity of fastening it in a



Ward in Boston Lying-in Hospital, showing Norinkle Rubber Sheet in various positions.

firm position on the adjustable bed now in use.

Another development is the care of the sheet. Holders have been devised for the purpose of hanging them on the wall rather than rolling and placing them in storage.

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OCCUPATIONAL THERAPY AND REHABILITATION

Conducted by NORMAN F. BURNETTE, Canadian National Committee for Mental Hygiene, 102 College St., Toronto, Ont., and MRS. CARL HENRY DAVIS, Advisor in Occupational Therapy, 825 Lake Drive, Milwaukee, Wis.
Co-Editors: LORING T. SWAIM, M.D., 372 Marlboro St., Boston Mass., and MISS MARY E. P. LOWNEY, Room 272, State House, Boston, Mass.

OCCUPATIONAL THERAPY IN TUBERCULOSIS

BY LAURIE LEE ALLEN, M.D., SENIOR PHYSICIAN, MUIRDALE SANATORIUM, WAUWATOSA, WIS.

ABOUT seven years ago an industrial recreation department was organized at Muirdale Sanatorium, Wauwatosa, Wis., as a co-educational institution, giving both men and women equal chances to work off their ailments through the steady application of hand, heart, and mind. This diversion proved such a benefit to those patients who were able to take a part in this new enterprise that it was pronounced a success from the beginning.

The requirements for entry into the new school of therapy were at first one of our greatest problems, since so many of the sanatorium cases were far advanced pulmonary tuberculosis. However, through the close cooperation of the medical and nursing departments, a plan was soon devised which worked well. No pupil was permitted to take his exercise in the workshop until he had been under careful observation by his doctor and head nurse for at least two weeks, during which time his pulse and temperature were carefully noted. If normal over this period he might prove to be a good candidate, but this is always decided by the doctor in charge. In many instances a patient might have normal pulse and temperature, and yet be entirely unfit for exercise; and, on the other hand, in rare cases patients with slight temperature and with a pulse as high as 110 have been allowed to do light work in school with real physical and clinical benefits in that they have gained weight, and their temperature and pulse have approached the normal.

This, in my opinion, illustrates very vividly the therapeutic value of occupational therapy. It could almost be called the balm of hurt minds. The very thought which makes a patient realize that he is yet useful and can do things gives him an entirely different frame of mind. He throws off his morbidity and takes up the attitude of cheerfulness, hopefulness and happiness. No one can realize the value of such training unless he or she can live among and observe these people who derive such outstanding benefits.

The Muirdale occupational therapy department is entirely compatible with the medical and nursing departments which work in full cooperation. There is an exercise list made out every week by the physician in charge. This program gives the schedule of time allotted each patient for exercise. All beginners in the workshop start on one hour of exercise, but are prepared for this by having done light bed-side work with an instructor, and house work in the wards under the supervision of the head nurse before a permit to work in the occupational therapy department is granted. This, of course, is to test their strength and tolerance for physical exertion. Patients are observed very carefully while in class room—any abnormal change in temperature or pulse will necessitate a decrease in their working time, or a withdrawal from the department altogether. On the other hand, patients who show a tolerance for more work have their time increased until they reach the three hours' mark, which is the limit of our working hours in this department. Every pupil is carefully checked up at the end of each week to see how he or she re-acts to the exercise. Through this method it is possible to get a better line on the cases ready for discharge, thus giving some estimate of their physical endurance before sending them back into civil life. This, in my opinion, is one of the most important functions of this department.

The various courses of the school are as follows: leather-tooling, beadwork, silver and coppersmithing, light basketry, toy-making, simple furniture, decorative painting, permodello clay modeling and weaving on cardboard frames. In addition to these there is a sewing room, tailor shop, and a shoe cobbling parlor, for those who formerly worked at such trades. It has always been the custom of the instructor in charge to assist the pupils in choosing the line of work most adaptable to their talents. This method, of course, necessitates changing the pupils around until they discover the work to which they are best suited. No one is allowed to do any work which might result in a physical or mental strain, however slight.

Occupational therapy is still in its infancy, but it already has found its place as a therapeutic measure.

Another interesting feature of this department is that there is nothing commercial about it. Patients are not permitted to make articles for sale for their own profit because to do so would create quantity competition, with the consequent evil of over-work. On the contrary, it is the aim at all times to foster pride in quality of the work done rather than the quantity of the work turned out. They may, however, make articles for themselves or friends for the cost of the material, and surplus articles are sold by the department and the money received therefor turned back into the department. This helps to keep at a very low figure the budget set aside each year by the county for the maintenance of occupational therapy.

Bed-side occupational therapy has also played a winning game with some of the very sick patients of the institution. Although hopeless cases they have been brought good cheer by having something to occupy their minds.

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Some of the most classic work in hand painting has been done by one or two of the bed-ridden cases who have spent a few minutes a day in this diversion. Beadwork and light basketry have also created a great deal of interest among those whose temperature and pulse are not too high for this occupation. They have often expressed the desire for even more work than is permitted because of their interest in the work. Seldom is there a patient who can do some kind of craft work who does not enjoy it and anticipate the period when it is allowed.

In organizing an occupational therapy department the chief aim should be to get a competent instructor, one who not only is well-versed in the various arts and crafts, but who also has had experience in studying character. They should know something of applied psycology, and should be at ease in handling men, women, boys and girls. The success of this department depends on this type of teacher. With such efficiency there need never be the complaint that occupational therapy is not a success.

It is encouraging to learn that several pupils, after being discharged as arrested cases, have been given positions in this line in the various small sanatoriums in the West.

Occupational therapy work at Muirdale is not compulsory, but as it is considered a privilege to do this work there is no difficulty in keeping the department filled to capacity. The workshop is the pride of Milwaukee County, for during the past five years it has grown to be one of the most efficient and attractive workshops of the Middle West.

OCCUPATIONAL THERAPY AND THE U. S. VETERANS' BUREAU HOSPITALS

Occupational therapy work is being extensively promoted in the various veterans' bureau hospitals throughout the country, as is evidenced by the instructions which are frequently sent out by the United States Government to medical officers in charge of such institutions.

(1) It is desired that the medical officers in veterans' hospitals familiarize themselves with occupational therapy as available at their stations with a view of prescribing that form of occupational therapy which is most indicated from a therapeutic and economic standpoint.

(2) Americanization for ex-service men of foreign birth and instruction in elementary academic subjects for illiterates should receive especial consideration. It is often difficult to detect the illiterate and, when found, may be even more difficult to get him to enter the indicated classes, but tact and patience should be exercised with this end in view. Unless the mental or physical condition of the patient contra-indicates, an illiterate patient who remains in the hospital for a period of three months should have acquired at least the rudiments of reading and writing before leaving the hospital.

(3) In prescribing occupational therapy the first consideration is the value of the treatment to the patient, but the therapy should be carried on as economically as is consistent with the attainment of the best results. Often one craft may have equal therapeutic value to another, in which case the one requiring the less expensive material should be prescribed.

(4) The occupational director and chief aide should give especial attention to utilizing waste and salvaged material and to developing lines of treatment which will meet the therapeutic indications at a minimum of expense. For example, if cotton will serve the desired purpose, do not use wool; if wool will serve, do not use silk, if pine lumber will serve, do not use mahogany.

(5) Based on the amount of work being done and the outlook for the future, a careful estimate of the expenditure considered necessary for occupational therapy supplies and equipment is made for each station for the coming fiscal year, and it is imperative that requisitions for such equipment and supplies be kept within the amount allotted. Should an increased number of patients or other unforseen conditions make necessary the furnishing of supplies beyond the allotment, a statement should accompany such requisitions, setting forth in detail the reasons for the emergency.

(6) Care should be taken that the production of one type of article is not overemphasized, unless necessary to meet the therapeutic indications. However, as practically any form of occupational therapy is permissible with certain domiciliary cases, exception may be made with these types of cases when the by-products are required at the station or can be otherwise used to advantage.

(7) It should be emphasized that the articles are by-products and the patient should not be allowed to commercialize occupational therapy; but, in whatever form this therapy is prescribed, as high a degree of thoroughness and accuracy should be required as is consistent with the physical and mental condition of the patient.

NEWS ITEMS

Miss Marion Peterson spent the summer resting and visiting her family before taking up her new work at Miami Valley General Hospital, Dayton, Ohio.

Miss Sadie Kahn, formerly of Cook County Hospital, Chicago, Ill., has accepted a position in the new Private Pavilion of New Haven Hospital, New Haven, Conn.

Miss Evelyn Cooper resigned from her position at Walter Reed Hospital, Washington, D. C., and is visiting in New York.

Miss Elizabeth Armstrong has accepted a position at Long Island College, Brooklyn, N. Y. Miss Armstrong has been at Roosevelt Hospital for a number of years.

The New York Association of Dietitians had a booth at The Women's Activities Exhibit held at The Commodore by The Business and Professional Women's League of New York City the week of September 24. As all the members of the association generously responded the attempt to display the profession to the public was very successful. Much interest was displayed in the work and a large amount of literature on diets, etc., was distributed.

The industrial dietitians were represented by Mrs. Pendergast of The American Telephone and Telegraph Company. Miss Campbell of The Brooklyn Bureau of Charities represented the public health dietitians. The post-graduates at Mount Sinai, St. Luke's, Presbyterian, Fifth Avenue, Bellevue and The Brooklyn Hospitals demonstrated very attractively and scientifically the treatment of disease by diet. The diabetic trays and various diabetic foods were of special interest to the public.

ARIZONA'S PREVENTORIUM

The Arizona Anti-tuberculosis Association has just recently finished its first demonstration of the value of a preventorium at Prescott when the sixty day period in which ten children were treated was concluded. During that time proper medical care, hygienic surroundings and proper nourishment were given these children by a donation from Dr. John W. Flinn of Prescott.

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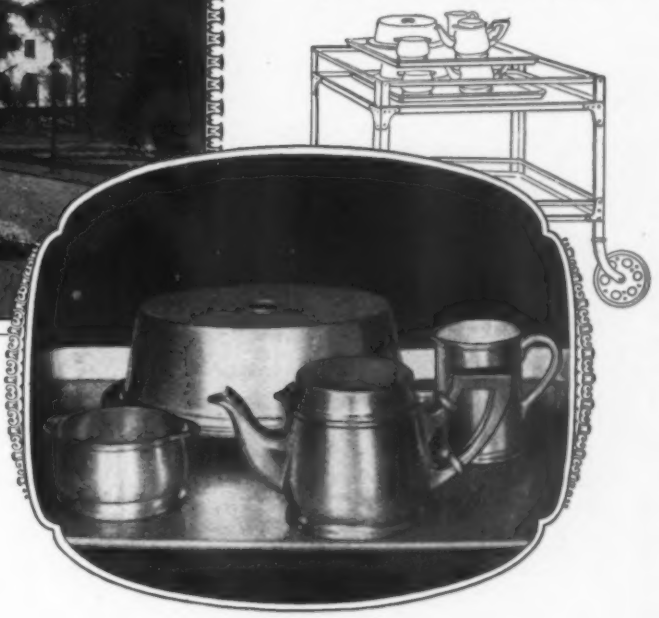

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News of the Hospitals and Sanatoriums

The department of "News of the Hospitals and Sanatoriums" is prepared each month just prior to going to press, for the purpose of presenting the latest authentic news regarding hospital construction, changes in personnel, and other matters in which the hospital field is interested. So far as we can ascertain, the sources of our information, while not guaranteed, are reliable.

General

Biography of General Gorgas.—The widow of the late Surgeon General William C. Gorgas, is collaborating with Burton J. Hendrick, author of "The Life and Letters of Walter H. Page," in preparing a biography of General Gorgas. It is hoped to be able to publish the biography during the coming year.

Compile Hospital Directory.—The National Tuberculosis Association has compiled a 126 page book containing a list of 662 sanatoriums, hospitals, day camps and preventoriums for the treatment of tuberculosis in the United States together with a list of government hospitals in which special provision is made for tuberculous patients. The location, date of opening, capacity, rates and superintendent in charge are given in each case.

Veterans' Hospital No. 26 to Be Discontinued.—No new patients are being received at the Veterans' Hospital No. 26, Camp Sevier, Greenville, N. C., it was recently announced. It is expected that the institution will soon be closed and the patients transferred to U. S. Veterans' Hospital No. 60, Oteen, N. C., where there are approximately 300 vacant beds. The Camp Sevier Hospital was established in 1919 and has a bed capacity of 700.

Hospitalization of Veterans.—The director of the Veterans' Bureau announced that he will enlarge the membership of the Central Board of Appeals of the bureau by adding a specialist in neuro-psychiatry and tuberculosis. The names of the additional members will be announced shortly. There are now 9,100 vacant beds in the government hospitals, an indication that the need for additional hospitals has passed, and that with proper distribution of patients there is abundant provision for their care. An investigation disclosed that it costs the government $5.78 daily per man for general hospital treatment, $5.30 for tuberculous treatment and $3.75 for neuropsychiatric treatment. Of these amounts, 53 cents is expended from every dollar for salaries, 27 cents for food, 7 cents for material and supplies and the remainder for such items as fuel, light and rent.

Bequests to Hospitals.—The Woman's Hospital, New York City, has received $2,000,000 and the Frederick Ferris Thompson Hospital, Canandaigua, has received $400,000 from the will of Mrs. Mary Clark Thompson. The residual portion of the estate of the late John H. Flager will be divided equally between the New York, St. Luke's and the Presbyterian Hospitals after $500,000 is given to the newly incorporated Alice Mandelick Flager Foundation for charitable purposes. Nurses are intended to be the chief beneficiaries of the foundation. The Home for Incurables and the Presbyterian hospitals, Philadelphia, together with two other sectarian institutions, are named in the will of the late George H. Buchanan. The four institutions are to receive the residue of a personal estate of more than $200,000, the bulk of which is left to two daughters of the testator. The Monmouth Memorial Hospital, Long Branch, N. J., has been left $60,000 for an addition to its nurses' home by Park M. Wolley of New York. Under the will of the Davis P. Kimball, Boston, the following will receive bequests: The Massachusetts General Hospital, $50,000; New England Hospital for Women and Children, the Children's Hospital and Infants' Hospital, Boston, and the Bertrand Home for Aged Men, Salem, Mass., each $10,000; the Home for Aged Colored Women, the Perkins Institution for the Blind, and the Industrial Home for Crippled and Deformed Children, Boston, each $5,000.

Alabama

New Children's Hospital.—Work has been started on a new building for the Children's Hospital, Birmingham. The addition is expected to be completed by December 1.

Open Walker County Hospital.—Information has been received that the new Walker County Hospital, Jasper, will be opened about October 10. Miss MacLean, superintendent of the Fraternal Hospital, Birmingham, is the new superintendent.

Arizona

Dr. Kingsley Resigns.—Dr. Alfred C. Kingsley has resigned as superintendent of the Arizona State Hospital for the Insane, Phoenix, and is temporarily taking charge of the Magma Hospital, Superior, while Dr. Chester R. Swackhamer is taking a vacation.

Arkansas

U. S. Veterans' Hospital.—Bids have been taken for the construction of six buildings, and additions to the nurses' quarters, and kitchen, of the U. S. Veterans' Bureau Hospital, Little Rock. Buildings will be of brick, tile, and reinforced concrete. Dr. Edwin P. Bledsoe is superintendent.

New Children's Hospital for Little Rock.—Plans for a children's hospital of fifty beds, to be built at Little Rock, are being prepared for the Arkansas Children's Home Finding Society. The work has been entrusted to Mr. John P. Almand, architect, of Little Rock, in collaboration with Dr. S. S. Goldwater, New York, N. Y., consultant.

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California

New Community Hospital.—The new community hospital, San Mateo, was opened for public inspection September 8.

New Maternity Building.—The new maternity building for the Fabiola Hospital, Oakland, will be opened to the public November 1, according to reports.

Sacramento County Hospital Has New Superintendent.—Dr. Albert K. Dunlap has been appointed superintendent of the Sacramento County Hospital to succeed Dr. H. E. Morrison, who recently resigned.

Enlarge Tuberculosis Unit.—The new addition to the tuberculosis unit of the Soldiers' Home Hospital, Sawtelle, will be completed in the next few weeks, it is announced. Harry Schenck, Dayton, Ohio, is the architect.

Enlarge Canyon Sanatorium.—A $20,000 addition consisting of kitchen, social hall and dining is to be built for the Canyon Sanatorium, Redwood City. James M. Guiness, Redwood City, is in charge of the architectural plans. Dr. Ralph B. Scheier is the medical director.

U. S. Veterans' Hospital.—San Fernando has been chosen as the site for the United States Veterans' Tuberculosis Hospital. The institution will, when completed, represent an expenditure of $2,000,000. Plans call for the cottage type of construction. Information has been received from the office of the Quartermaster General, Washington, D. C.

Erect Harmonic Sanitarium.—Foundations have been laid for four six-room buildings for the new Harmonic Sanitarium, Buena Park. The exterior will be of concrete with composition roofing. Details of the structure have not yet been announced. The total cost is estimated at $16,000. M. Eugene Durfee, Anaheim, has been chosen architect. Miss Myrtle E. Petroff is superintendent of the sanitarium.

Dr. Morrison Resigns.—Dr. Henry E. Morrison, superintendent of the Sacramento Hospital, Sacramento, has resigned following his "exoneration" by the grand jury when charged with mismanagement of the institution. Last May the charge was brought up that Dr. Morrison's conduct was unbecoming, and that the institution was mismanaged. The entire student body, with one exception, and all of the graduate nurses, resigned some weeks ago.

To Survey County Hospital.—A committee of five physicians will make a survey of the medical administration of the county hospital, Riverside, and report to the county supervisors in the near future. This, it is reported, is part of the plan of co-operation agreed on by the local physicians and the supervisors when the medical society was given supervision of the medical administration of the hospital. The committee appointed to make the survey includes: Drs. William W. Roblee, Hugh R. Martin, Wendell A. Jones, Bonnie O. Adams and Arthur L. Brown.

Colorado

Children's Hospital Enlarged.—An addition is being erected to the Children's Hospital, Denver, having a present capacity of seventy-five beds. The exterior is of brick and concrete construction with composition roofing. The new building will be about 100 by 75 feet in size and will cost $175,000. E. H. Moorman, Denver, is the architect.

Illinois

Close Detention Hospital.—It is planned to close the Detention Hospital, Rock Island, and to have St. Anthony's Hospital take care of patients having contagious diseases.

Cottage for Tuberculous Patients.—The Illinois State Association of graduate nurses, Chicago, will erect a cottage for tuberculous patients at Naperville Sanatorium.

Enlarge Old Ladies' Home.—Bids are being taken for an addition to the Old Ladies' Home, Chicago, it is announced. Holabird & Roche, Chicago, are the architects.

Enlarge Lakeside Hospital.—Architects Lawrence, Reppel & Ratchliffe are drawing plans for a new $200,000 addition to the Lakeside Hospital, Chicago. T. K. Johnston is the manager.

Install Deep Therapy Apparatus.—The laboratories of Lake View Hospital, Danville, were recently enlarged to make room for a new deep therapy apparatus. The machine installed was one of the largest types being made.

Addition to West End Hospital.—Plans are being drawn by Architects Harris & Jillson for a five-story and basement addition to the West End Hospital, Chicago. Information may be obtained from Dr. Ben Breakstone.

Plan Nurses' Home and Addition.—An addition to the Methodist Hospital of Central Illinois and a nurses' home, Peoria, are being planned, according to a recent announcement. Architects have not yet been selected. Joseph Miller is superintendent of the hospital.

New Six-Story Hospital.—Foundation has been started for the new $500,000 six-story hospital to be located at 556-70 Flourney Avenue, Chicago. J. E. Pridmore, Chicago, is the architect. Details may be obtained from Dr. D. B. Ramsey, 5660 W. Lake St., Chicago.

Remodel Cottage Hospital.—The Cottage Hospital, Howard, is to be remodeled and thoroughly equipped with all the latest known appliances, according to a recent announcement. It will have a total capacity of fifty beds, and a nurses' training school. Information may be obtained from Dr. I. I. Frisch, Chicago.

Nurses' Home Nears Completion.—The new nurses' home, Washington Boulevard Hospital, Chicago, is under construction and will be completed early in December, it is announced. It is a three-story and basement English type with 150 sleeping rooms, library, diet kitchen, classroom, demonstration room and assembly hall. Berlin and Swern, Chicago, are the architects.

Announce Research Fellowships.—Michael Reese Hospital, Chicago, announces the establishment of the John K. Hertz and Joseph G. Syndacker research fellowships of $30,000 each and the Gusta Morris Rothschild and Albert Kuppenheimer research funds of $50,000 each. The first fellowship is offered by Mr. and Mrs. John Hertz, the second by the trustees of the Joseph G. Syndacker estate, and the third by the trustees of the Gusta Morris Rothschild estate and the fourth by Albert Kuppenheimer.

Lay Murphy Memorial Cornerstone.—The cornerstone of the John B. Murphy Memorial Hall adjacent to the headquarters of the American College of Surgeons, 44 E. Erie St., Chicago, was laid Tuesday afternoon, October 23. More than 3,000 American surgeons, many of whom were attending the clinical congress of the American College of Surgeons attended the ceremony. Dr. William J. Mayo, Rochester, Minn., delivered the address upon the laying of the cornerstone. The building will be erected at a cost of $500,000, and will be used to house the library of the organization.

Idaho

Hospital Head Named.—Dr. Richard G. Eaton assistant superintendent, Easton State Hospital, Medical Lake, Washington, has been appointed superintendent of the Idaho Insane Asylum, Blackfoot, to succeed Dr. Clayton A. Hoover, who resigned recently.

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